

11880

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11855

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Fairgreen Circle				d. STREET ADDRESS 9 Fairgreen Circle			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIS Middle LOOSE Last ALTENDERFER		4. DATE OF DEATH Month October Day 5 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1886	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Representative		10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Hamburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irwin B. Altenderfer				14. MOTHER'S MAIDEN NAME Agnes Loose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-4463		17. INFORMANT Mrs. Ethel Altenderfer Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420-80 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO 3 yrs. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma							INTERVAL BETWEEN ONSET AND DEATH minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to Oct. 5 19 60 , that (I) (we) last saw the deceased alive on Oct 5 19 60 , and that death occurred at 6:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Enter - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 10 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

BP

Source: *U.S. Census Bureau*.

DEPT. OF AGRICULTURE

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

Figure 1. Illustrative example of the proposed

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11881

11856

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 15 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 545 N. Locust St.	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Minnie First May Middle Aushman Last		4. DATE OF DEATH Month October Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Near Downsville, Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Wells		14. MOTHER'S MAIDEN NAME Jennie Graham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Grace M. Kershner Hagerstown, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease c Decompensation 20 days DUE TO Anemia Due To Nutritional & Loss Of Blood Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Concussion DUE TO (c) Fractures Of Rt. Radius, Nasal Bones & Maxillae			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down the steps at home.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9-25- 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Hagerstown, Washington, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>[Signature]</i>		DATE SIGNED 10-17-60	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-18-60	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24. REC'D BY REGISTRAR OCT 20 '60	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11882
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11857

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 321 WEST SIDE AVE?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SYLVIA First LEONA Middle AUSHERMAN Last		4. DATE OF DEATH OCTOBER Month 28 Day 19 Year 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER T. BAKER		14. MOTHER'S MAIDEN NAME SARAH BYREM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. JOSEPHINE MOATS		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 18 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 13, 1959 to Oct. 28, 1960 , that (I) (we) last saw the deceased alive on Oct. 27, 1960 , and that death occurred at 1 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE R.A. Bell		22b. DATE SIGNED 10-28-60	
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		22d. ADDRESS Hagerstown, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/31/60	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Norman, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE NOV 1 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1188

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

11883

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11858

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address, or institution) <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>W. Franklin ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>O.</u> Middle <u>BAILEY</u> Last				4. DATE OF DEATH <u>OCT</u> Month <u>10</u> Day <u>1960</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 5, 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Landis Tool Co</u>			
11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Anna Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>173-03-0182</u>			
17. INFORMANT <u>Mrs. Patterson Dixon</u>				Address <u>W. Franklin ST. Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arterio-Sclerotic Hart Dis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 wks</u> <u>yes -</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 to <u>10 Oct 1960</u> , that (I) (we) last saw the deceased alive on <u>9 Oct 1960</u> , and that death occurred at <u>5:55 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Chwebe</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>				23b. DATE THEREOF <u>10/12/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				23d. LOCATION (City, town, or county) (State) <u>Greencastle Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u>				25a. REC'D BY REGISTRAR <u>OCT 13 '60</u>			
ADDRESS <u>Greencastle, Pa.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kious</u>			

1188

1188

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Discernible words include:]

George Washington
Attorney General
Secretary of State
President
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11884 CERTIFICATE OF DEATH 11859									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1113 Beechwood Drive					d. STREET ADDRESS 1113 Beechwood Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle VIRGINIA Last BARNES					4. DATE OF DEATH Month October Day 15 Year 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1877		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Falling Waters, W.Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Warner Emerson					14. MOTHER'S MAIDEN NAME Clara Virginia Burke				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-2646B		17. INFORMANT Address Mrs. Edith Clary 1113 Beechwood Dr. Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerosis general (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 4 yrs. 4 yrs.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 16 19 60 to Oct 15 19 60 , that (I) (we) last saw the deceased alive on July 20 19 60 , and that death occurred at 6 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Philip J. Hirshman					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/60		
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.					22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town, or county) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel					ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank

Wm. A. Horst

45211



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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>					c. LENGTH OF STAY IN 1b <u>40 Yrs.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>May</u> Last <u>Barnes</u>					4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>19 60</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15. 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine Operator (Shoe)</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Fulton County Penna.</u>				
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Charles W Barnes</u>					14. MOTHER'S MAIDEN NAME <u>Jane A Bishop</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-09-5225</u>				
17. INFORMANT <u>Mrs Jessie E Mc Cusker Little Orleans Md.</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>1 Day</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>10/3/60</u> to <u>10/4/60</u> , that (I) (we) last saw the deceased alive on <u>10/4/60</u> and that death occurred at <u>10/4/60</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ralph Young</u>					22b. DATE SIGNED <u>10/7/60</u>				
22c. PHYSICIAN'S NAME (Type) <u>Ralph Young</u>					22d. ADDRESS <u>Williamsport Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>10.8.60</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>St Patricks Cemetery</u>					23d. LOCATION (City, town, or county) (State) <u>Little Orleans Allegany Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Shone</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>				
ADDRESS <u>Hagerstown</u>					25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>				

11880

WARRANT OF HABEAS CORPUS
IN FAVOR OF
COLUMBIA OF DEATH

11881

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VR A15 (4)
ISM 9/59

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11886
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11861

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital (D.O.A.)		d. STREET ADDRESS 108 N. Potomac St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle Edward Last Bender		4. DATE OF DEATH Month Oct. Day 20 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6 1908
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 8 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Cement	
11. BIRTHPLACE (State or foreign country) Sharpsburg Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Webster Lee Bender		14. MOTHER'S MAIDEN NAME Myrtle May Hebb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 18 1001	
17. INFORMANT Mrs. Minnie Myrtle Bender		108 N. Potomac St Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578x DUE TO Hemorrhage of the upper gastrointestinal tract - gastric or oesophageal Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 12 hours DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from on Oct. 20, 1960 , 19____, that (I) (we) last saw the deceased alive on 10/20/60 , and that death occurred at 9A M, from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy		22b. DATE 10/21/60	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 22-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williams		25a. REC'D BY REGISTRAR OCT 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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CERTIFICATE OF DEATH

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VR A15 (4)
15M 9/59

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11965
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11862

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home				d. STREET ADDRESS 10X-2			
3. NAME OF DECEASED (Type or print) First LeRoy Middle George Last BLICKENSTAFF				DATE OF DEATH Month 10 Day 18 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1883	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Cyrus Blickenstaff				14. MOTHER'S MAIDEN NAME Flora Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 212-24-5031		17. INFORMANT J. Woodrow Blickenstaff, Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1960 , to Oct 17, 1960 , that (I) (we) last saw the deceased alive on Oct 17, 1960 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE G. W. Wickham M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/19/60	
22c. PHYSICIAN'S NAME (Type) G. W. Wickham				22d. ADDRESS Boonsboro Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/20/1960		23c. NAME OF CEMETERY OR CREMATORY Grossnickle Cem.		23d. LOCATION (City, town, or county) (State) Frederick Co., Md	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company,				ADDRESS Middletown, Md.		25a. REC'D BY REGISTRAR DATE OCT 21 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

11805

STATE OF TEXAS

11805

IN SENATE,
January 11, 1905.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1904.
BY
J. M. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS BOOK CONCERN, 1905.

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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel W.</u> Middle <u>Bayce</u> Last <u>Bayce</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-15-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stable-Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fred. Co. Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-1953</u>	
17. INFORMANT <u>J.S. Bayce - 417-Middle St. Fred.</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lobular pneumonia, bilateral</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral thrombosis</u> DUE TO (c) <u>general arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>11 months</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Nephrosclerosis, bilateral</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1</u> , 19 <u>60</u> , to <u>October 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 12</u> , 19 <u>60</u> , and that death occurred at <u>2:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor L. Ramos</u>		ADDRESS (Street, city or town, state) <u>Western Md. State Hospital</u> DATE SIGNED <u>Oct. 12, 1960</u>	
PHYSICIAN'S NAME (Type) <u>VICTOR L. Ramos, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-17-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ceres Bethel A.M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Burkittsville-Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks</u>		ADDRESS <u>Frederick-Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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CERTIFICATE OF DEATH

(M)

Westminster

Harriet Mary

Western Methodist Church

M. C. 1892-1893

Trinity Co. Md.

W. H. Brown

W. H. Brown

Trinity Co. Md.

Trinity Co. Md.

Trinity Co. Md.

Trinity Co. Md.

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Trinity Co. Md.

Trinity Co. Md.

Trinity Co. Md.

11864

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USAL PLACE OF DEATH (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 6 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WILLIAMSPORT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RT.#2 WILLIAMSPORT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE ELIZABETH BRINING		4. DATE OF DEATH Month OCTOBER Day 25 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1907	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID E. HOSE		14. MOTHER'S MAIDEN NAME MARY JANE RUBECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 270-34-0211		17. INFORMANT MR. GUY L. BRINING	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cerebral Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) None		20g. (County) None		20h. (State) None	
21. I certify that (I) (this hospital) attended the deceased from Sept 24, 1960 , to Oct 25, 1960 , that (I) (we) last saw the deceased alive on Oct 25, 1960 , and that death occurred at 3 A.M. from the causes and on the date stated above.					
22a. SIGNATURE John D. Turco		22b. PHYSICIAN'S NAME (Type) Dr. John D. Turco		22c. ADDRESS 302 N. Potomac Street-Hagerstown, Md	
22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED 8-26-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/27/60		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	
23d. LOCATION (City, town, or county) HAGERSTOWN MD		23e. REC'D BY REGISTRAR DATE OCT 27 '60		23f. REGISTRAR'S SIGNATURE Arthur L. Hume	

11804

CERTIFICATE OF DEATH

11804

W. J. Bennett, Registrar

11889
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11865

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>West Md. State Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>222 Summit Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine Love</u> Middle <u>Clipp</u> Last <u></u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Scott Roland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Helene Kennedy</u>		Address <u>610 Chestnut St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction, anterior</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis, severe</u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign nephrosclerosis</u> (b) <u>old posterior infarction</u> (c) <u>cerebral thrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lung infarction</u>	
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u></u> Hour a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 16, 1960</u> to <u>Oct. 24, 1960</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 24, 1960</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos</u> M.D.		22b. DATE SIGNED <u>Oct. 24, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos</u>		22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EDGE HILL Cemetery</u>	23d. LOCATION (City, town, or county) <u>Charles Town</u> (State) <u>W. Va.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u></u> DATE <u>OCT 26 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. RFD #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Sharpsburg Pike			
3. NAME OF DECEASED (Type or print)		First Herbert		Middle Wilson		Last Cullison	
4. DATE OF DEATH		Month Oct.		Day 12		Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26 1889	
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months 7 Days 15		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator Sub Station Power Plant				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John E. Cullison				14. MOTHER'S MAIDEN NAME Frances Catherine Sprinkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217 10 9495			
17. INFORMANT Mrs. Samuel Palmer				Address Sharpsburg Pike Hagerstown Md. RFD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177x Vremia DUE TO Ca of Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 11 1960 to Oct 12 1960 , that (I) (we) last saw the deceased alive on Oct 12 1960 , and that death occurred at 11:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Wm. P. Turner				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF Oct. 15-60		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Carlton D. Wilson				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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COMMUNICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11891

11867

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Since June-1960		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 235-A East Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last clarence Parker Custis				4. DATE OF DEATH Month Day Year October 12 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 21 Sept 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doorman		10b. KIND OF BUSINESS OR INDUSTRY Theatre		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert P. Custis				14. MOTHER'S MAIDEN NAME Phoebe Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address H. Powell Custis, Onanock, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 141.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma (squamous cell) base of tongue DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) @ coronary atherosclerosis, moderate (b) @ nephrosclerosis, benign							INTERVAL BETWEEN ONSET AND DEATH 4 days 6 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 13</u> 19 <u>60</u> , to <u>October 12</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>October 12</u> 19 <u>60</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos, M.D.				22b. DATE SIGNED Oct. 13, 1960		22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, m.d.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-14-60		23c. NAME OF CEMETERY OR CREMATORY Onanock Cemetery		23d. LOCATION (City, town, or county) (State) Onanock, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Farris	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302 11868

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 19 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 648 No Prospect St		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 648 No Prospect St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CALVIN DALEY		4. DATE OF DEATH Month Day Year October 2 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostler P.R.R.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Daley		14. MOTHER'S MAIDEN NAME Mary Stouffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 713-07-9297	
17. INFORMANT Address Norman Daley 648 No Prospect St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) fractured aortic arch DUE TO Emphysema (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH 4 days 70 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 20 1960 to Oct 2 1960 , that (I) (we) last saw the deceased alive on Oct 2 1960 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE A. E. Smith		22b. DATE SIGNED 10/3/60	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Tipton Jr.		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR DATE OCT 5 '60	

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CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE

DATE

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE

DATE

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G27310-14-60 et

CERTIFICATE OF DEATH

11869

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b ?	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland Cumberland 10102.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 329 Central Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NIAL DARR Middle Last		4. DATE OF DEATH Oct. 7, 1960 Month Day Year 19	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1919
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Cumberland Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward A. Darr		14. MOTHER'S MAIDEN NAME Venetia Page	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. MEDICAL RECORD	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 606X DUE TO PROBABLE MESENTERIC THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Postoperative - permanent cystostomy and evacuation sev. months bladder calculi (c) Neurogenic bladder 10 months		INTERVAL BETWEEN ONSET AND DEATH 36 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Quadriplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs December 1959	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct. 4, 1960 19 to Oct. 7, 1960 19, that I last saw the deceased alive on Oct. 6, 1960 19, and that death occurred at 7:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 King St., Hagerstown, Md. DATE SIGNED Oct. 7, 1960		
ACTUAL SIGNATURE Joseph C. Crisp M.D. M.D.		
PHYSICIAN'S NAME (Type) JOSEPH C. CRISP, M. D.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
Burial	10/10/60	Rose Hill Cem.
22d. LOCATION (City, town, or county) (State)		
Cumberland Md		
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.		24a. REC'D BY REGISTRAR DATE OCT 10 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

DECEASED NAME: WILLIAM LAST NAME: WILLIAM FIRST NAME: WILLIAM MIDDLE NAME: WILLIAM		SEX: MALE AGE: 40 DATE OF BIRTH: 1900 PLACE OF BIRTH: 1900	
OCCUPATION: WILLIAM PLACE OF DEATH: WILLIAM DATE OF DEATH: 1900 TIME OF DEATH: 1900		CAUSE OF DEATH: WILLIAM MANNER OF DEATH: WILLIAM PLACE OF DEATH: WILLIAM DATE OF DEATH: 1900	
SIGNATURE OF DECEASED: WILLIAM SIGNATURE OF WITNESS: WILLIAM SIGNATURE OF PHYSICIAN: WILLIAM SIGNATURE OF CLERK: WILLIAM		SIGNATURE OF DECEASED: WILLIAM SIGNATURE OF WITNESS: WILLIAM SIGNATURE OF PHYSICIAN: WILLIAM SIGNATURE OF CLERK: WILLIAM	

THIS CERTIFICATE IS VALID FOR THE STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11894

11870

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 5 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. STREET ADDRESS I25 E. FRANKLIN ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MABEL Middle N. Last DEATRICH				4. DATE OF DEATH Month IO Day 6 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 21, 1879	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY FED. GOVT.			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN D. TURNER				14. MOTHER'S MAIDEN NAME MARTHA J. PITTINGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MARGARET GREENE		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Peritonitis DUE TO (c) Post-operative appendectomy							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from Aug 3, 1960 to Oct 6, 1960 that (I) (we) last saw the deceased alive on Oct 6, 1960 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. John D. Turco				22b. DATE 10-7-60		22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco	
22d. ADDRESS 302 N. Potomac Street-Hagerstown, Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS 302 N. Potomac Street-Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/8/1960		23c. NAME OF CEMETERY OR CREMATORY BROADFORDING		23d. LOCATION (City, town, or county) (State) BROADFORDING, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS				ADDRESS HAGERSTOWN, MD.		25a. REC'D BY REGISTRAR DATE OCT 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus				25c. REGISTRAR'S SIGNATURE Arthur L. Kraus		25d. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11870

STATE OF OHIO

11871



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

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11969
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11871

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 W. Antietam Street		d. STREET ADDRESS 123 W. Antietam St/	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Belle Last Delauney		4. DATE OF DEATH Month Oct. Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27 1868
9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months 7 Days 29	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John W. Fisher		14. MOTHER'S MAIDEN NAME Helen Hines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Mervin Delauney		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 10/20/60 , that (I) (we) last saw the deceased alive on 10/22 19 60 , and that death occurred at 6:15P from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy		22b. DATE SIGNED Oct. 28, 1960	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22d. ADDRESS Sharpsburg, Md;	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 28-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf-Williamson		25a. REC'D BY REGISTRAR DATE OCT 31 '60	
ADDRESS med		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

11331

CERTIFICATE OF DEATH

11331

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11895

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 11 Film G274 10-31-60 et

CERTIFICATE OF DEATH

11872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 440 Salem Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margie Ann Drury		4. DATE OF DEATH Month Day Year Oct. 19 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1960
9. AGE (In years last birthday) yrs. 3 Min. 52		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Bishop Drury		14. MOTHER'S MAIDEN NAME Betty Virginia McCarney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Infl.) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 19, 1960 , to Oct. 19, 1960 , that I last saw the deceased alive on Oct. 19, 1960 , and that death occurred at 12:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. D. Wilson		ADDRESS (Street, city or town, state) 135 N. Potomac St., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) J. D. Wilson, Md.		DATE SIGNED 10/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/21/60	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hospital Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy B. Turner, M.D.		24a. REC'D BY REGISTRAR DATE OCT 25 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2081308XV0

CERTIFICATE OF DEATH

DECEASED'S NAME [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]	
MARITAL STATUS [REDACTED]		PRESENT RESIDENCE [REDACTED]		PLACE OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]		PLACE OF INTERMENT [REDACTED]	
SIGNATURE OF DECEASED'S NEXT OF KIN [REDACTED]		SIGNATURE OF MEDICAL ATTENDANT [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in form 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11873
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.			c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 31 W. Bethel Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle George Last Dunkin, Jr.					4. DATE OF DEATH Month Oct Day 10 Year 19 60					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8 19 56		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Daniel G. Dunkin					14. MOTHER'S MAIDEN NAME Estella Duckett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Daniel G. Dunkin 47 W. North.					Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound Of Head DUE TO Conditions, if any, which gave rise to immediate cause (b) Intracranial Hemorrhage (a), stating the underlying cause last. DUE TO (c) Shock INTERVAL BETWEEN ONSET AND DEATH 3 hours										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in head while playing with revolver.							
20c. TIME OF INJURY Month, Day, Year Hour 5:30 p. m. 10-10-1960			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 31 W. Bethel St., Hagerstown, Washington, Md.		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>[Signature]</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					10-12-60
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R Watson Jr Hagerstown Md.</i>					24a. REC'D BY REGISTRAR DATE OCT 14 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

MEDICAL CERTIFICATION

4. 4. 2016

1907

James Smith

032002

62-11-9-11-94

230107 - 051000Z

James G. Thompson, Jr. 17 Nov 1917

11897

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11874

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle E Last EBBERTS		4. DATE OF DEATH Month October Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 18, 1889
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Casual	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ebberts		14. MOTHER'S MAIDEN NAME Sarah Ann Ebberts (Maiden Name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-9414	
17. INFORMANT Mr. Clyde Gift		Address 314 N. Prospect St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/9 19 60 , to 10/13 19 60 , that (I) (we) last saw the deceased alive on 10/13 19 60 , and that death occurred at 7:15 M., from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Campbell		22b. DATE SIGNED 10/14/60	
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell		22d. ADDRESS HAGERSTOWN Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		25a. REC'D BY REGISTRAR DATE OCT 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1140

CERTIFICATE OF DEATH

1140

Washington, D.C.
No. 1140
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Race
Marital Status
Occupation
Signature of Physician
Signature of Registrar
Date of Registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11898

11875

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Fulton</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Cove Tannery</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>75X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>-----</u> Last <u>Edwards</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Berks Co. Penn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Joe Everets</u>		Address <u>Big Cove Tannery Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Prostate Hypertrophy with Uremia.</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> <u>6 Months.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15</u> , 19 <u>60</u> , to <u>Oct. 31</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10/31/60</u> 19 <u>60</u> and that death occurred at <u>11:25 P.M.</u> on the date stated above.			
22a. SIGNATURE <u>J. G. Warden</u>		22b. ADDRESS <u>832 Potomac Ave., Hagerstown, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. G. Warden, M. D.</u>		22d. ADDRESS <u>832 Potomac Ave., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-4-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Big Cove Tannery, Penn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 4 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE <u>NOV 4 '60</u>	

11847

CERTIFICATE OF DEATH

11847

Blank form with faint horizontal lines and some illegible text.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11876

11970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>			c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sharpsburg Md. RFD #1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharpsburg Md RFD #1</u>				d. STREET ADDRESS <u>Sharpsburg Md. RFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Floyd Albin Eichelberger</u>				4. DATE OF DEATH Month Day Year <u>Oct. 25 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2 1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>John Eichelberger</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>232 01 0460</u>		17. INFORMANT Address <u>Sharpsburg Md.</u> <u>Mrs. Della Eichelberger RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide from gunshot wound through brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/25/60</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11899

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11877

(M)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 501 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernice Middle Virginia Last Farrell				4. DATE OF DEATH Month Oct. Day 15, Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1906	
9. AGE (In years last birthday) yrs. 54		10. UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.		11. UNDER 24 HRS. Months 5 Days 10 Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) practical nurse				10b. KIND OF BUSINESS OR INDUSTRY nursing Home		11. BIRTHPLACE (State or foreign country) Warren Co., Virginia	
13. FATHER'S NAME John Alexander				14. MOTHER'S MAIDEN NAME Effie V. Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 229-03-8697		17. INFORMANT Address Bruce Farrell, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 10 yrs (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13th Oct. 1960 to 15th Oct. 1960 that (I) (we) last saw the deceased alive on 14th Oct. 1960 and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks				22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10/17/60		22c. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-60		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City, town, or county) (State) Tilghmanton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 18 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

11/17/47

STATE OF OHIO

IN SENATE

January 15, 1948

101, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1900

1910

1920

1930

1940

1950

11966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro			c. LENGTH OF STAY IN 1b 14 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeders Nursing Home			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Nannie Middle Mae Last Ferguson			4. DATE OF DEATH Month Oct. Day 11 Year 19 60		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1879		9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mt. Aetna, Md.	
13. FATHER'S NAME John Detrow			14. MOTHER'S MAIDEN NAME Catherine Hoffman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-20-1832		INFORMANT Address Edith I. Baker, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from October 11, 1960 to October 11, 1960 that I last saw the deceased alive on October 11, 1960 , and that death occurred at 4 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Ferguson		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
PHYSICIAN'S NAME (Type) JOSEPH SECONDARI		BOONSBORO MD -			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-14-60		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	
				22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.			24a. REC'D BY REGISTRAR OCT 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

11838

CERTIFICATE OF DEATH

11838

Wash.

Dist.

Washington

San Francisco

14 days

Boonshoro

14 W. Main St.

Boonshoro Nursing Home

Oct. 12, 1900

Yerkes

Male

Female

Sept. 10, 1898

Female White

1000 W. Main St.

Housewife

Charlotte Hoffman

John Brown

219-20-1000 with L. Baker, Baker Town, Md.

no

Handwritten notes:
14 W. Main St.
Boonshoro Nursing Home

San Francisco, Md.

San Francisco Cemetery

10-12-00

Boonshoro & Son, San Francisco, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11879

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 140 W. Antietam Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First MARY Middle JORDAN Last FITZPATRICK				4. DATE OF DEATH Month October Day 28 Year 1960											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1897		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer				10b. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William A. Fitzpatrick				14. MOTHER'S MAIDEN NAME Margaret Jordan											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-10-7377				17. INFORMANT Andrew J. Fitzpatrick Address Hagerstown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443 X IMMEDIATE CAUSE (a) Cerebral Hemorrhage - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Advanced Hypertensive Cardiac - DUE TO (c) vascular disease												INTERVAL BETWEEN ONSET AND DEATH 4-6 hrs 2-3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from OCT 27 1960 to OCT 28 1960 , that (I) (we) last saw the deceased alive on OCT 27 1960 , and that death occurred at 1:15 PM , from the causes and on the date stated above.															
22a. SIGNATURE Edward W. Ditto III, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/29/60							
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.				22d. ADDRESS 217 West Washington St.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/31/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Hanley				ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE NOV 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes					

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11801

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11881

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nagerstown Rural # Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lantz Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>		d. STREET ADDRESS <u>10X-2</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>R.</u> Middle <u>Fox</u> Last		4. DATE OF DEATH <u>Oct. 20</u> Month <u>1960</u> Day Year	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25, 1869</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmern</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John P. Fox</u>	
14. MOTHER'S MAIDEN NAME <u>Cornelia Buhrman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>287-20-2540</u>		17. INFORMANT <u>Glenn E. Fox</u> Address <u>Lantz, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1969</u> to <u>Oct 20, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct 18, 1969</u> and that death occurred on <u>Oct 20, 1960</u> at <u>4:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David R. Brewer</u> M.D.		22b. DATE SIGNED <u>10/20/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		22d. ADDRESS <u>Clear Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Foxville Fred, Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont, Md.</u>	25a. REC'D BY REGISTRAR <u>OCT 24 '60</u> DATE
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

11881

STATE DEPARTMENT
BUREAU OF INDIAN AFFAIRS
WASHINGTON, D. C.
CERTIFICATE OF DEATH

11881

[Faint, mostly illegible text and markings on a form, possibly containing names and dates.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11901

11882

Item 9 Film 274 11-4-60 et

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pauline Middle May Last Frick		4. DATE OF DEATH Month Oct. Day 31 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16 1914
9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Benjamin Frnaklin Hunsberger		14. MOTHER'S MAIDEN NAME Rhoda May Cramer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George Frick Address Williamsport Md. RFD #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anorexia (oscheria) DUE TO 199.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bowel obstruction (small bowel) DUE TO 1 mo (c) Diffuse carcinoma DUE TO 1 yr		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1 to Oct 31 19 60 that (I) (we) last saw the deceased alive on Oct 30 19 60 and that death occurred at 6:30 a.m. from the causes and on the date stated above.			
22a. SIGNATURE M E Byrkit		22b. DATE SIGNED Oct 31, 1960	
22c. PHYSICIAN'S NAME (Type) M E Byrkit		22d. ADDRESS 28 W Potomac Williamsport Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2-60	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L Leaf Williamsport Md		25a. REC'D BY REGISTRAR NOV 2 '60	
		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

11501

CERTIFICATE OF DEATH

11502

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Undertaker

Signature of Burial Society

Signature of Cemetery

Signature of Health Officer

Signature of Police Officer

Signature of Coroner's Jury

Signature of Medical Officer

Signature of Health Officer

Signature of Medical Officer

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Signature of Medical Officer

Signature of Medical Officer

Signature of Medical Officer

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11883

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>10X-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L.</u> Last <u>Gilbert</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>19 60</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/1896</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Babington</u>			14. MOTHER'S MAIDEN NAME <u>Jennie Harshman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Milton M. Gilbert, Myersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure with anoxia</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hall stones</u>						INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 23, 1960</u> to <u>Oct 23, 1960</u> , that I last saw the deceased alive on <u>Oct 23, 1960</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10/25/60</u>							
ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>Dr. John C. Stauffer</u> <u>Hagerstown, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/26/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 137 W. WASHINGTON ST. HAGERSTOWN, MD.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11903

11884

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				e. STREET ADDRESS 1320 ANTIETAM DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DALE Middle R. Last GRAMS				4. DATE OF DEATH Month OCTOBER Day 10 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 1 1909		9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 4 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARKING LOT ATTENDANT				10b. KIND OF BUSINESS OR INDUSTRY LOCUST VALLEY FRED. CO. MD. U.S.A.		11. BIRTHPLACE (State or foreign country) FRED. CO. MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN W. GRAMS			
14. MOTHER'S MAIDEN NAME MABEL GRAMS DETROIT				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 220-09-7082				17. INFORMANT MRS. JOSEPHINE GRAMS Address 320 ANTIETAM DRIVE HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Renal Disease DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 5 1960 to Oct 10 1960 , that (I) (we) lost the deceased alive on Oct 10 1960 , and that death occurred at 6 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad, M.D.				22b. DATE SIGNED 90-12-60		22c. PHYSICIAN'S NAME (Type) Robert P. Conrad	
22d. ADDRESS Hagerstown, Md.				22e. REC'D BY REGISTRAR OCT 14 '60			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF OCT. 14, 1960		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY	
23d. LOCATION (City, town, or county) LOCUST GROVE WASH. CO. MD.				23e. REGISTRAR'S SIGNATURE Arthur S. Kline			
24. FUNERAL DIRECTOR'S SIGNATURE John W. Baer				24b. ADDRESS BRONSBORO MD			

11484

11903

CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
CERTIFICATE NO.: [illegible]
REGISTERED AT: [illegible]
DATE OF REGISTRATION: [illegible]
SIGNATURE: [illegible]
OFFICIAL SEAL: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

11904

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11885

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Emert Last Guessford				4. DATE OF DEATH Month Oct. Day 18 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13 1878	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 1 Days 4		11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U. S. A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Otho Guessford				14. MOTHER'S MAIDEN NAME Margaret Wolford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215 01 9951		17. INFORMANT Address Pinesburg RFD Williamsport Md Mrs. Viola May Guessford	
18. CAUSE OF DEATH [Enter only one cause for the for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Ac. myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Interval between onset and death DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/18/60 to 10/18/60 , that (I) (we) last saw the deceased alive on 10/18/60 , and that death occurred 10/18/60 M, from the causes and on the date stated above.							
22a. SIGNATURE Robert F. Young				22b. DATE SIGNED 10/18/60		22c. PHYSICIAN'S NAME (Type) Robert F. Young	
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 20-60		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
23d. LOCATION (City, town, or county) (State) Williamsport Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md				25a. REC'D BY REGISTRAR DATE OCT 19 60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1122



404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

11905
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11886

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Virginia b. COUNTY Jefferson	
c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Box 446	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLIFFORD Middle PAUL Last GUNN		4. DATE OF DEATH Month October Day 3 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman-Engineer		10b. KIND OF BUSINESS OR INDUSTRY Steel Plant	
11. BIRTHPLACE (State or foreign country) Mobile, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zacharia P. Gunn		14. MOTHER'S MAIDEN NAME Clara ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 259-01-5998	
17. INFORMANT Mrs. Reubena Gunn		Address Charlestown, W. Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with auricular fibrillation, acute (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 96 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic carcinoma right lung, post-pneumonectomy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-7- 19 60 to 10-3- 19 60 , that (I) (we) last saw the deceased alive on 10-3- 19 60 , and that death occurred at 8:15 AM from the causes and on the date stated above.			
22a. SIGNATURE John H. Kehne, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D.		22d. ADDRESS 131 W. Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1960	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Super - Rouzer Funeral Home		25a. REC'D BY REGISTRAR OCT 6 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

NOTES

2000

2748 JI

6. *Journal of the American Medical Association*, 1990; 263: 1033-1036.

2000.11.10

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Figure 1. Schematic diagram of the experimental setup.

1990

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11906

11887

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			c. LENGTH OF STAY IN 1b <u>ONE MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>NORTH MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Alice</u> Last <u>Hahn</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 13, 1878</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BRANDYWINE VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE C. REXRODE</u>				14. MOTHER'S MAIDEN NAME <u>SARAH J. PROBST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CHARLES E. HAHN BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUKEMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>pyelonephritis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Hypertensive cardiovascular disease ② coronary artery disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 8</u> , 19 <u>60</u> , to <u>Oct. 27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct. 27</u> , 19 <u>60</u> , and that death occurred at <u>3:00</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>October 27, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>				22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 29, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BROWNSVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

11908

11587

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WASHINGTON

MARYLAND

WASHINGTON

REGISTERED

DECEASED

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of State Health Officer

Signature of State Surgeon General

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11907

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11888

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VERNIE VIOLA HAYS				4. DATE OF DEATH Month Day Year OCTOBER 31 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/1883	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRA W. HAYS				14. MOTHER'S MAIDEN NAME FLORA VIOLA HOUSEHOLDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT REV. CLIFFORD HAYS Address CRISCO PENNA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 190.9 DUE TO Intra-cardiac metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Malignant Melanoma of vulva. metastases (c) with generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							INTERVAL BETWEEN ONSET AND DEATH Immediate 6 mo. + 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-4 19 60 , to 10-31 19 60 , that (I) (we) last saw the deceased alive on 10-31 19 60 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Omar D. Sprecher, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-2-60	
22c. PHYSICIAN'S NAME (Type) Omar Daniel Sprecher, Jr. M.D.				22d. ADDRESS 314 N. Potomac St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/3/60		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Korman				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 4 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kneiss			

11-22

STATE OF TEXAS
COUNTY OF DALLAS

11004

Know all men by these presents, that I, JOHN A. HAYES, of the County of DALLAS, State of TEXAS, for and in consideration of the sum of ONE HUNDRED DOLLARS, to JOHN A. HAYES in hand paid by JOHN A. HAYES, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said JOHN A. HAYES, all that certain ONE acre of land, situate in the County of DALLAS, State of TEXAS, more particularly described as follows, to-wit:

ONE acre of land, situate in the County of DALLAS, State of TEXAS, more particularly described as follows, to-wit:

ONE acre of land, situate in the County of DALLAS, State of TEXAS, more particularly described as follows, to-wit:

1

Witness my hand and seal of office this 11th day of November, 1911, at the City of DALLAS, State of TEXAS.

JOHN A. HAYES

Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11889
11973										CERTIFICATE OF DEATH
										Reg. Dist. No.
1. PLACE OF DEATH o. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ohio b. COUNTY Jackson					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade				c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Hill 72X-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Barracks T 135, Ft. Ritchie					d. STREET ADDRESS 412 Hiland Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle WILLIAM Last HERMAN					4. DATE OF DEATH Month Oct. Day 1 Year 19 60					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Dec. 1930		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Massillon, Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Carl William Herman, Sr.					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 271-28-1704		17. INFORMANT Address Sgt. Jack A. Heinz, CQ, US MP & SEC. CO.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending autopsy report. Amended 880.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) certified with followup DUE TO (c) Acute alcoholic intoxication Approx. 2-3 hrs.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Imbibition of large quantity of alcohol at a rapid rate							
20c. TIME OF INJURY Month, Day, Year Hour a. m. Oct. 1 1960 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House party		20f. (City or town) (County) (State) Blue Ridge, Washington Md			
21. I certify that I attended the deceased from N/A , 19____, to____, 19____, that I last saw the deceased alive on____, 19____, and that death occurred at____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Patrick J. Ferraro M.D. 10/4/1960										
ACTUAL SIGNATURE Patrick J. Ferraro M.D. 10/4/1960										
PHYSICIAN'S NAME (Type) Patrick J. Ferraro, Capt., M.C. Ft. Ritchie, Cascade, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/60		22c. NAME OF CEMETERY OR CREMATORY Oak Hill C.M. Cemetery			22d. LOCATION (City, town, or county) (State) Oak Hill Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE J. Martin Roe ADDRESS Waynesboro, Penna.					24a. REC'D BY REGISTRAR DATE OCT 6 '60		24b. REGISTRAR'S SIGNATURE Clifton S. Finner			

VS A15 (4)
 15M 10/57

CERTIFICATE OF DEATH

11-17-38

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11908

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

11890

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROGER Middle CHARLES Last HERSHEY		4. DATE OF DEATH Month October Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14 1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President Southern Shoe Co		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown Wash Co Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Winfield Scott Hershey		14. MOTHER'S MAIDEN NAME Mary Jane Wolfkill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2164	
17. INFORMANT Mrs Violet Hershey		Address 821 Potomac Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple emboli DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular fibrillation + congestive failure (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 week Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gout		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gout	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7 19 60 , to Oct 11 19 60 , that (I) (we) last saw the deceased alive on Oct 11 19 60 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE R. S. Stauffer		22b. DATE SIGNED Oct 11 1960	
22c. PHYSICIAN'S NAME (Type) R. S. STAUFFER		22d. ADDRESS Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. BURIAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR Oct 17 1960	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Charles L. House	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11909

Reg. Dist. No. 11891

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Manor Home</u>		d. STREET ADDRESS <u>236 East Antietam Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ellen Gertrude Hess</u>		4. DATE OF DEATH Month Day Year <u>Oct. 29 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>80</u> yrs.
		11. BIRTHPLACE (State or foreign country) <u>Emmitsburg Fred. Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John S. Hess</u>		14. MOTHER'S MAIDEN NAME <u>Agnes J. Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Miss Emma Hess</u> <u>1222 Virginia Ave Hagerstown Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. W. Ditto</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-1-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>
		22d. LOCATION (City, town, or county) <u>Hagerstown Wash. Co. Md.</u>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Huns</u>	

1 11974 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>9 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown #6</u>				d. STREET ADDRESS <u>Hagerstown #6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arena</u> Middle <u>May</u> Last <u>Holtzman</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/14/1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife, Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>220-18-1240</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg, Hag., #5</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ottis Smith</u>				14. MOTHER'S MAIDEN NAME <u>Anna Nigh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>C. Boyd Holtzman, Hagerstown Md., #6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1951, to <u>Oct. 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>60</u> , and that death occurred at <u>8:05 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				ADDRESS (Street, city or town, state) <u>M.D. 148 West Washington St. Hagerstown, Md.</u>		DATE SIGNED <u>10/7/60</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Waynesboro, Franklin Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Grove, Waynesboro Penna.</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>Oct 10 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Rimes</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11910
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11893

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) 339 JEFFERSON ST.		d. STREET ADDRESS 339 JEFFERSON ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle CLEVELAND Last HOSE		4. DATE OF DEATH Month OCTOBER Day 13 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1884
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 13 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DINGY OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY CEMENT MFG.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. HOSE		14. MOTHER'S MAIDEN NAME MARY E. BAUGHMAN HAGERSTOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS MARY J. HOSE		Address MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Pulmonary Edema DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to Oct 13, 1960 , that (I) (we) last saw the deceased alive on Oct 7, 1960 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
22a. SIGNATURE B. B. KNEISLEY		22b. DATE SIGNED 10/14/60	
22c. PHYSICIAN'S NAME (Type) B. B. KNEISLEY		22d. ADDRESS 1486 Washington St. Hagerstown MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/16/60	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norwood, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kneisley			

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NEW YORK
OFFICE OF THE
COMMISSIONER OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11975
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11894

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING		c. LENGTH OF STAY IN 1b 53 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle LOIS Last HULL		4. DATE OF DEATH Month IO Day 29 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 8, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ZACKARAH SHIVES		14. MOTHER'S MAIDEN NAME AMANDA SNIDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JESSEL L. HULL SR.		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE WITH HEMIPLEGIA DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 19, 1960 to OCT. 29, 1960 , that (I) (we) last saw the deceased alive on OCT. 29, 1960 , and that death occurred at 2.55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED OCT. 31, 1960	
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		22d. ADDRESS CLEAR SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 1, 1960	
23c. NAME OF CEMETERY OR CREMATORY ST. PAULS		23d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		25. REC'D BY REGISTRAR DATE NOV 2 '60	
ADDRESS CLEAR SPRING, MD.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

11331

CERTIFICATE OF DEATH

11331

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11911

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11895

1. PLACE OF DEATH o. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 6 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1315 Virginia Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First E Middle May Last Hutson		4. DATE OF DEATH Month 10 Day 5 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1892 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 67 Days 67 Hours 67 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Siler		14. MOTHER'S MAIDEN NAME Adelia Pearril	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Walter R. Hutson		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & cardiac decompensation DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH 1 day sev year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1/55 19 to 10/5/60 19 that (I) (we) last saw the deceased alive on 10/4/60 19 and that death occurred at 3A M. from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M.D.		22b. DATE SIGNED 10/5/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 North Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR OCT 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss	

11837

CERTIFICATE OF DEATH

11011

Washington

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11912

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11896

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 03 Years Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 11105 Potomac Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSH First HORNER Middle JACKSON Last		4. DATE OF DEATH October Month 19 Day 1960 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired taylor		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Mc Connellsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hahson Jackson		14. MOTHER'S MAIDEN NAME Louise Lehman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-7896	
17. INFORMANT Mrs. Evelyn Jackson		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aneurysm of aorta (abdominal) DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 4 days years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Under nutrition		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 Dec 1956 to 19 Oct 1960 , that (I) (we) last saw the deceased alive on 19 Oct 1960 , and that death occurred at 4 P. M. from the causes and on the date stated above.		22a. SIGNATURE Richard T. Binford M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10/20/60	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD M.D.		22d. ADDRESS 1135 Potomac Ave. Hagerstown Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/1960	
23c. NAME OF CEMETERY OR CREMATORY Norland Cemetery		23d. LOCATION (City, town, or county) (State) Chambersburg Penn.	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR OCT 24 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1151

1151

CERTIFICATE OF DEATH

Registration

Registration

Registration

Registration

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Registration

1100 Lawrence Ave.

San Francisco County Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN 1b 7 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland d. STREET ADDRESS 214 1/2 N. Jonathan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Husten Franklin Johnson				4. DATE OF DEATH Month Oct Day 3 Year 1960											
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 23 1899		9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY janitor				11. BIRTHPLACE (State or foreign country) Warenton, Va.				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME John W. Johnson				14. MOTHER'S MAIDEN NAME Syvilla Mitchell											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 201-14-6075				17. INFORMANT Mary Davis Address 214 1/2 N. Jonathan St							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO 420-8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO Heart Disease (c) 191 INTERVAL BETWEEN ONSET AND DEATH 2 wks.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug 5 1960 to Oct 3 1960 , that (I) (we) last saw the deceased alive on Oct 3 1960 , and that death occurred at 8 P M, from the causes and on the date stated above.															
22a. SIGNATURE Philip J. Hirshman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.				22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 7 1960				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson				ADDRESS Hagerstown Md				25a. REC'D BY REGISTRAR DATE OCT 11 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

1182

RECEIVED

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11-11-11

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11913

11897

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b MINUTES			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORMA Middle FLORENCE Last JOHNSON				4. DATE OF DEATH Month OCTOBER Day 30 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 10 1907 - 53 yrs.	
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) CORONA N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. WILLIAM K. BOUTON				14. MOTHER'S MAIDEN NAME MARY KNOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-36-3570		17. INFORMANT MISS SARA JOHNSON Address 431 GUILFORD AVE HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Nov. 11 19 60 , to Oct 30 19 60 , that (I) (we) lost the deceased alive on Oct 30 19 60 , and that death occurred at 8:10 PM , from the causes and on the date stated above.							
22a. SIGNATURE Philip J. Hirshman				22b. ADDRESS 159 W. Washington St. Hagerstown, Maryland		22c. DATE SIGNED 10/31/60	
22d. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.				22e. ADDRESS 159 W. Washington St. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 1, 1960		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town, or county) HAGERSTOWN WASH. CO MD (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Boon ADDRESS BOONSBORO MD.				25a. REC'D BY REGISTRAR NOV 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

DR. HIRSHMAN
159 W. WASH. ST.
HAGERSTOWN

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LEWIS CASE OF DEATH

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DECEASED

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WILLIAM LEWIS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11899

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11976

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR BOONSBORO</u> MINUTES c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 404</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>NO. 2, WEST HOWARD ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND B. JOHNSON</u> First Middle Last				4. DATE OF DEATH <u>OCTOBER 27 - 1960</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>AUGUST - 16 - 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CHAIN STORE OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>McDONALD PENNA.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>MATHIAS JOHNSON</u>			
14. MOTHER'S MAIDEN NAME <u>ELEANOR McCAUSLAND</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>096-10-9736</u>				17. INFORMANT <u>MRS. NURMA JOHNSON HAGERSTOWN MD.</u> Address <u>2 - WEST HOWARD ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease, Severe</u> DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>5 years</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-29-60</u>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>OCT. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>HAGERSTOWN MD.</u> (State)		24a. REC'D BY REGISTRAR <u>DATE NOV 3 '60</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>BOONSBORO MD.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. DITTO JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
11915
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11900

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE 03 b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 906 Salem Ave.		d. STREET ADDRESS 906 Salem Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE First MAY Middle KALMEY Last		4. DATE OF DEATH October 16, 1960 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-1878 1878
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State of foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James P. Watts		14. MOTHER'S MAIDEN NAME Sarah Phelps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Some Address Lee Kalme; 906 Salem Ave., Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1953 to 10-16-60 , 19, that (I) (we) last saw the deceased alive on 10-12-60 , 19, and that death occurred at 8:15P , from the causes and on the date stated above.			
22a. SIGNATURE Paul Harrison		22b. DATE 10-17-60	
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1960	
23c. NAME OF CEMETERY OR CREMATORY St Annes Cent		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Laylusino		25a. REC'D BY REGISTRAR OCT 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

M

CHINESE PATENT

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13092

11977

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasantville		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasantville	
4. DATE OF DEATH Month October Day 29 Year 19 60		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle RANDOLPH Last KERN		4. DATE OF DEATH Month October Day 29 Year 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1871	
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min. 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith Shop	
11. BIRTHPLACE (State or foreign country) Harpers Ferry, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Kern		14. MOTHER'S MAIDEN NAME Louisa Roeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Catherine Grove		18. RFD #1, Harpers Ferry, West Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Serious DUE TO (b) Serious DUE TO (c) Serious Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28-1960 to 10-29-1960 that (I) (we) last saw the deceased alive on 10-29-1960 and that death occurred on 10-29-1960 at 10A M, from the causes and on the date stated above.			
22a. SIGNATURE C. E. Pratt		22b. DATE SIGNED 10-29-60	
22c. PHYSICIAN'S NAME (Type) C. E. Pratt		22d. ADDRESS Barnesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Bolivar, Jefferson Co., WVA.	
24. FUNERAL DIRECTOR'S SIGNATURE Donald E. Cables		25a. REC'D BY REGISTRAR NOV 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneib		25c. DATE NOV 8 '60	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

11978

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11901

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RINGGOLD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RINGGOLD</u>			
c. LENGTH OF STAY IN 1b <u>9 YEARS</u>				d. STREET ADDRESS <u>1 SMITHSBURG MD. 132</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RINGGOLD MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA N KLINE</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER - 17 - 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 3. 1869</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>BEAVER CREEK WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
13. FATHER'S NAME <u>DANIEL ROHRER</u>				14. MOTHER'S MAIDEN NAME <u>MARY NELSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. JAMES A. KLINE</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 Yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> 19 <u>54</u> , to <u>10/17</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>60</u> and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. Hess</u>				22b. DATE SIGNED <u>10/18/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>	
22d. ADDRESS <u>Smithsburg, Md.</u>				22e. REC'D BY REGISTRAR <u>OCT 25 '60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>OCT. 20, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>BEAVER CREEK WASH. CO. MD</u>				23e. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Boat. BOONSBORO MD</u>				25. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 1 day		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital					d. STREET ADDRESS 24 1/2 W. Franklin			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Jesse Middle L Last Kline					4. DATE OF DEATH Month 10 Day 5 Year 19 60														
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7, 1892		9. AGE (In years last birthday) 67 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Big Spring, Md.			12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME Luke C. Kline					14. MOTHER'S MAIDEN NAME Annie Bowers														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 1 214-09-6578		17. INFORMANT Address Mrs. Susie Kline Hagerstown, Md.															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO Arteriosclerosis (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 3 days year																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no		20f. (City or town) (County) (State) no												
21. I certify that (I) (this hospital) attended the deceased from Jan 29, 1960 to Oct 5, 1960 , that (I) (we) last saw the deceased alive on Oct 4, 1960 , and that death occurred at 11 PM , from the causes and on the date stated above.																			
22a. SIGNATURE Louis G. Graff					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/5/60											
22c. PHYSICIAN'S NAME (Type) Louis G. GRAFF					22d. ADDRESS 119 E. Antietam A														
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-8-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City, town, or county) (State) Hagerstown Md.												
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss					ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss										

1

11916

11902

11942



CERTIFICATE OF DEATH

11916



Washington

1900-1901

1901-1902

1902-1903

1903-1904

1904-1905

1905-1906

1906-1907

1907-1908

1908-1909

1909-1910

1910-1911

1911-1912

1912-1913

1913-1914

1914-1915

1915-1916

1916-1917



1917-1918

1918-1919

1919-1920

1920-1921

1921-1922

1922-1923

1923-1924

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11917

11903

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 1 YR.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 2330 JEFFERSON BLVD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELINOR Middle RICKERD Last KLIPP				4. DATE OF DEATH Month OCTOBER Day 2 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/1883	
9. AGE (In years last birthday) 76 yrs.		10. AGE (In years last birthday) 76 yrs.		11. AGE (In years last birthday) 76 yrs.		12. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SILAS RICKERD				14. MOTHER'S MAIDEN NAME MARY HART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. HERBERT L. KLIPP	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebral thrombosis DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Dissection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 hour Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 53 to 2 Oct 19 60 , that (I) (we) last saw the deceased alive on 1 Oct 19 60 , and that death occurred on 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE J. D. WILSON, M.D.				22b. DATE SIGNED 10/3/60			
22c. PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.				22d. ADDRESS 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/4/60		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION (City, town, or county) (State) FREDERICK MD.	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison, Frederick, Md.				25a. REC'D BY REGISTRAR DATE OCT 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

11903

11015

CERTIFICATE OF DEATH
BUREAU OF VITAL STATISTICS
STATE OF NEW YORK

DECEASED

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PROPERTY

DECEASED'S SIGNATURE

WITNESSES

DOCTOR

CLERK

NOTARY

DECEASED'S ADDRESS

DECEASED'S OCCUPATION

DECEASED'S RELIGION

Wm R. Stetson, Funeral Mgr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
11918										
11904										
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 58 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 S. PROSPECT ST.					d. STREET ADDRESS 128 S. PROSPECT ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHESTER Middle C. Last KNEPPER					4. DATE OF DEATH Month 10 Day 22 Year 1960					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 25, 1886		9. AGE (In years less birthday) yrs. 74		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY BOWLING ALLEY		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES D. KNEPPER					14. MOTHER'S MAIDEN NAME ANN E. MILLER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-3691		17. INFORMANT MRS. FLORENCE KNEPPER			Address HAGERSTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralysis Agitans 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.								INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 25, 1959 to Oct. 22, 1960 , that (I) (we) last saw the deceased alive on Oct. 20, 1960 , and that death occurred at 5P M, from the causes and on the date stated above.										
22a. SIGNATURE R.A. Bell					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 24, 1960.			
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.					22d. ADDRESS Hagerstown, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/25/1960		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL			23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS					ADDRESS HAGERSTOWN, MD.		25a. REC'D BY REGISTRAR DATE OCT 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss	

11904

CERTIFICATE OF DEATH

11904

Blank certificate form with faint horizontal lines and vertical columns for data entry. The form includes fields for name, age, sex, race, date of death, and cause of death. There are also sections for the attending physician and the funeral home. The form is oriented horizontally on the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR A15 (4)
ISM 9/59

11919

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11905

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		d. STREET ADDRESS 121 WEST SIDE AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROBIN SUE KNODE		4. DATE OF DEATH Month Day Year IO 23 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. IO, 1959
9. AGE (In years last birthday) yrs. IO		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT F. KNODE		14. MOTHER'S MAIDEN NAME PATSY ARMSTRONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ROBERT F. KNODE		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxia - (vomit aspiration) 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Viral gastroenteritis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10 19 59 to 12/23 19 60 , that (I) (we) last saw the deceased alive on 12/23 19 60 , and that death occurred at 10 M, from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Skoff		22b. DATE SIGNED 10/24/60	
22c. PHYSICIAN'S NAME (Type) Louis G. Skoff		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 119 E. Antietam	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF IO/26/1960	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL		23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		ADDRESS HAGERSTOWN, MD.	
25a. REC'D BY REGISTRAR DATE OCT 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

11002

CERTIFICATE OF DEATH

11011

(Interp. Nov) - 11/20
attestation Nov

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11/20 11/20
L. J. Davis
17000 D. Davis

11/20 11/20 11/20

Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled out by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11920
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11906

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 41 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNE First WRIGHT Middle KOHLER Last		4. DATE OF DEATH October 29 19 60 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Denver, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Wright		14. MOTHER'S MAIDEN NAME Katherine Bolleter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT J. Earl Kohler		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with extensive metastases to lungs & liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 153.8 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH about 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/6 1940 to 10/29 1960 , that (I) (we) last saw the deceased alive on 10/28 1960 , and that death occurred at 11:54 M, from the causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 10:31:60	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/1960	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Syler - Rouzer Funeral Home		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Finner			

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1577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11979
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11907

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>State Line Post Office (Wash. Co., Md.)</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u> d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Jane</u> Last <u>Koons</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George A. Koons</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Newman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Ruth L. Koons</u> Address <u>(Wash. Co., Md.) State Line</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic Heart Dis. & Congestive Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>40 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 60</u> to <u>16 Oct 60</u> that (I) (we) last saw the deceased alive on <u>15 Oct 19 60</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>P. F. WEISSTER</u>	
22d. ADDRESS <u>GREENCASTLE -</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>10/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
23d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u> ADDRESS	
25a. REC'D BY REGISTRAR <u>OCT 20 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
11980
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11908

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Conv. Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 833 Maryland Ave	
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle AGNES Last KREGLO		4. DATE OF DEATH Month October Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 19 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fernandas Fox		14. MOTHER'S MAIDEN NAME Virginia Kneisley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas M. Harr		Address 833 Maryland Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronch pneumonia DUE TO Carcinoma Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 3 days 20 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20-60 to 10-21-60 , that (I) (we) last saw the deceased alive on 10-20-60 , and that death occurred at 7 A M, from the causes and on the date stated above.			
22a. SIGNATURE A. E. W. Dittus		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr E W Dittus		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR DATE OCT 26 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

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TRINITY OF CHURCH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11921
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11909

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle A. Last KYLUS		4. DATE OF DEATH Month 10 Day 22 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-17-1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52 Days 22 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Cadillac Lounge	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Kylus		14. MOTHER'S MAIDEN NAME Anne Grable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-8631	
17. INFORMANT Mrs. A.W. Resser, 419 Louisiana Ave.,		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 191.3 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Carcinoma of left cheek and throat DUE TO (c) 18 months		INTERVAL BETWEEN ONSET AND DEATH one week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis of coronary arteries.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20, 1960 to Oct 22, 1960 that (I) (we) last saw the deceased alive on Oct 22, 1960 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE Oct. 23, 1960	
22c. PHYSICIAN'S NAME (Type) Young E. Chun, M.D.		22d. ADDRESS 1500 Penna. Ave. Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-25-60	
23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town, or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		25a. REG'D BY REGISTRAR Oct 26 1960	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		25c. REGISTRAR'S NAME Arthur L. Kline	

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UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-374301)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11-15-60

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]



Very truly yours,

Special Agent in Charge

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove attendant papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11922

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11910

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 39 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 61 Randolph Ave.							
3. NAME OF DECEASED (Type or print) First GEORGE Middle LAMBILLOTTE Last LAMBILLOTTE				4. DATE OF DEATH Month October Day 6 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1881	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glazer				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Berthol Lambillotte				14. MOTHER'S MAIDEN NAME Paulina Schmidt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-30-9699		17. INFORMANT Address Mrs. Firmine Lambillotte Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis 153.8 DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 months ?							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 60 , to Oct 6 19 60 , that (I) (we) last saw the deceased alive on 6 Oct 19 60 , and that death occurred at 3³⁰ M, from the causes and on the date stated above.							
22a. SIGNATURE E. H. Hoodlark M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/7/60	
22c. PHYSICIAN'S NAME (Type) E. H. Hoodlark				22d. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/1960		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE OCT 13 '60		25b. REGISTRAR'S SIGNATURE C. S. Suter	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film 273 10-24-60 et

11923

11911

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hancock Hagerstown	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 2600 Virginia Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lincoln Middle Andrew Last Landis		4. DATE OF DEATH Month Oct. Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7 1861
9. AGE (In years lost birthday) 98 yrs.		IF UNDER 1 YEAR 11 Months 6 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Union Deposit Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Martin Landis		14. MOTHER'S MAIDEN NAME Barbara Hooker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. E. J. Whitmore		Address Martinsburg W. Va. RFD #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420-0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic Heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10.13.60 , 19 60 , to 10.14.60 , 19 60 , that (I) (we) last saw the deceased alive on 10.14.60 , 19 60 , and that death occurred at 4 P. from the causes and on the date stated above.			
22a. SIGNATURE S. Earl Young		22b. ADDRESS 148 N. Potomac St., Hagerstown, Md.	
22c. PHYSICIAN'S NAME (Type) S. Earl Young M.D.		22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 17-60	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery	23d. LOCATION (City, town, or county) (State) Western Pike Hagerstown RFD
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Wilkerson, Md.		25a. REC'D BY REGISTRAR DATE OCT 18 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

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Washington County Hospital

11924										DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										11912																																																																					
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																																																																															
a. COUNTY					Washington					MARYLAND					a. STATE					Maryland					b. COUNTY					Allegany																																																											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					Hagerstown					c. LENGTH OF STAY IN 1b					2 Months					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					Mt Savage																																																																
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					Western Maryland State Hospital					d. STREET ADDRESS					51X-2					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																					
3. NAME OF DECEASED (Type or print)					First Aden					Middle Joseph					Last LAVIN					4. DATE OF DEATH					Month 10					Day 7					Year 1960																																																						
5. SEX					Male					6. COLOR OR RACE					White					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH					April 4, 1900					9. AGE (In years lost birthday)					60 yrs.					IF UNDER 1 YEAR					IF UNDER 24 HRS.																																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					Tavern operator					10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country)					Maryland					12. CITIZEN OF WHAT COUNTRY?					U. S. A.																																																						
13. FATHER'S NAME					John Lavin					14. MOTHER'S MAIDEN NAME					Rebecca Folk					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					No					16. SOCIAL SECURITY NO.					213-09-9875					17. INFORMANT					Mrs. Fanny Lavin					Address					Mt Savage, Maryland																																		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										Acute respiratory insufficiency										INTERVAL BETWEEN ONSET AND DEATH										2 weeks																																							
527.1										DUE TO										Pulmonary emphysema, diffuse.										5 years																																																											
Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost.										DUE TO																																																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																																																															
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town)										(County)										(State)																																							
Hour o. m.										While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>																																																																															
p. m.										19																																																																															
21. I certify that (I) (this hospital) attended the deceased from Aug 11 1960 to Oct 7 1960 that (I) (we) last saw the deceased alive on Oct 7 1960 and that death occurred at 9:45 PM from the causes and on the date stated above.										22a. SIGNATURE										Young E. Chun										M.D.										ATTENDING PHYS. <input type="checkbox"/>										MED. DIRECTOR <input type="checkbox"/>										STAFF PHYS. <input checked="" type="checkbox"/>										22b. DATE										Oct 8, 1960									
22c. PHYSICIAN'S NAME (Type)																				22d. ADDRESS										1500 Penna. Ave. Hagerstown, Md																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify)										Burial										23b. DATE THEREOF										10/10/60										23c. NAME OF CEMETERY OR CREMATORY										Methodist Cemetery										23d. LOCATION (City, town, or county)										Mt Savage										Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE										H. Lee Silcox										Cumberland										Maryland										25a. REC'D BY REGISTRAR										DATE										OCT 10 '60										25b. REGISTRAR'S SIGNATURE										Arthur S. Kraus									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 6 YRS. d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 122 S. LOCUST ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CECIL IRVIN LEATHERMAN		4. DATE OF DEATH OCTOBER 27 19 60							
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/1893	9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ASSEMBLER		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT MFG. CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN MARLON LEATHERMAN		14. MOTHER'S MAIDEN NAME ESTELLA SPESSARD							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-14-1777		17. INFORMANT MRS. R. MAUDE LEATHERMAN Address HAGERSTOWN MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 757.1 IMMEDIATE CAUSE (a) Bilateral polycystic kidney disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH not determined									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____						
21. I certify that (I) (this hospital) attended the deceased from Oct. 27 1960 that (I) (we) last saw the deceased alive on Oct. 27 1960 , and that death occurred at 1:10 P.M. from the causes and on the date stated above.									
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED Oct. 28, 1960							
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/30/60		23c. NAME OF CEMETERY OR CREMATORY BROADFORDING CHURCH CEM. WASHINGTON CO. MD.					
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR NOV 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. H...					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11926					11914				
CERTIFICATE OF DEATH 302									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida Polk COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakeland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital					d. STREET ADDRESS 1511 Boone Court				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First DAVID Middle ELWYN Last LEONARD					4. DATE OF DEATH Month Oct Day 5 Year 1960				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 18 1881		9. AGE (In years last birthday) 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Australia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME No Record					14. MOTHER'S MAIDEN NAME No Record				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-5870		17. INFORMANT Address Mrs Jean Darley 27 Laurel St					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Past operative shock 5 days DUE TO (b) Past operative shock 5 days DUE TO (c) Past operative shock 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/26/60 to 10/5/60 , that (I) (we) last saw the deceased alive on 10/5/60 19____, and that death occurred at 2 P M, from the causes and on the date stated above.									
22a. SIGNATURE SEARL YOUNG					22b. DATE SIGNED 10/5/60				
22c. PHYSICIAN'S NAME (Type) SEARL YOUNG					22d. ADDRESS 48 M. Potomac St. Hagerstown Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.					25a. REC'D BY REGISTRAR DATE OCT 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11915

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Frederick St		d. STREET ADDRESS 232 Frederick St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Lizer Jr.		4. DATE OF DEATH Month October Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1958
9. AGE (In years lost birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Frederick Md.		12. CITIZEN OF WHAT COUNTRY? None	
13. FATHER'S NAME John W. Lizer Sr.		14. MOTHER'S MAIDEN NAME Jacqueline Johnston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jacqueline Johnston		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, acute lymphatic 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 204.3 (c) 204.3			INTERVAL BETWEEN ONSET AND DEATH May 1960
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 12 -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 9-15-58 19____, to death 19____, that (I) (we) last saw the deceased alive on 10-5-60 19____, and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert F. Keadle PH M.D.		22b. DATE SIGNED October 7, 1960	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle		22d. ADDRESS 318 North Potomac Street, Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-9-60	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR Hagerstown Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE OCT 10 '60	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11967
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11916

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 75 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 W. Potomac Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Stake Last Malott		4. DATE OF DEATH Month Oct. Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker		10b. KIND OF BUSINESS OR INDUSTRY Brick Co	
11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Elias Malott		14. MOTHER'S MAIDEN NAME Molly Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 18 0309	
17. INFORMANT Mrs. Harry Volker		17. ADDRESS 123 W. Potomac St. Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Left Mammary Gland DUE TO 162-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 mo. Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 22 1960 to Oct 29 1960 , that (I) (we) last saw the deceased alive on Oct 28 1960 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 1-60	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		24. ADDRESS Williamsport, Md.	
25a. REC'D BY REGISTRAR DATE NOV 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

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11517

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11928
11917
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 17 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1120 SALEM AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SIGMUND Middle ISADORE Last MANDELL		4. DATE OF DEATH Month OCTOBER Day 6 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL MANDELL		14. MOTHER'S MAIDEN NAME ODESSA GADEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1069-12-6636	
17. INFORMANT MRS. LILLIAN MANDELL		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute ventricular fibrillation (probable) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arteriosclerotic (coronary) heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 6 years -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-6 1960 to 10-6 1960 , that (I) (we) last saw the deceased alive on 9-23 1960 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 10-7-60	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/8/60	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		25a. REC'D BY REGISTRAR OCT 10 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
Oct. 7, 1960

22c. NAME OF CEMETERY OR CREMATORY
Rocky Springs Cemetery

22d. LOCATION (City, town, or county) (State)
Frederick County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

M. R. Etchison & Son, Frederick, Maryland

24a. REC'D BY REGISTRAR
DATE OCT 6 '60

24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus

11930

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11919

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlocks Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth McCann				4. DATE OF DEATH Month Day Year October 13 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1869	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John A. Doarnberger				14. MOTHER'S MAIDEN NAME Roseann Fridinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <input type="checkbox"/>		17. INFORMANT Address Mrs. Rose Wolf Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arteriosclerosis - General DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to Oct 13 , 19 60 , that (I) (was) lost saw the deceased alive on Oct. 13 , 19 60 , and that death occurred 6:54 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Ed A. Hoffman M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Ed A. Hoffman	
22d. ADDRESS 214 N. Pot-st. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

11931										11920									
MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH										CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown d. STREET ADDRESS Route 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Anna First McCormick Middle --- Last					4. DATE OF DEATH Month October Day 1 Year 19 60														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1887		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		IF UNDER 24 HRS. Hours 73 Min. 73							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Near Clearspring Md.				12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME John Sands					14. MOTHER'S MAIDEN NAME Belle Unknown														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ---		17. INFORMANT Elmer C. McCormick Address Route 6													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X pneumonia & osteoarthritis C.V.H. DUE TO (b) 2 wks Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsons Disease										INTERVAL BETWEEN ONSET AND DEATH 2 wks									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 9/10/54 19 --- , to 10/1/60 19 --- , that (I) (we) last saw the deceased alive on 9/29/60 19 --- , and that death occurred at 5A AM , from the causes and on the date stated above.																			
22a. SIGNATURE Howard N. Weeks, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/3/60											
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 North Potomac St., Hagerstown, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town, or county) (State) Hagerstown Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR OCT 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

11320

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 5/59

11932										11921									
MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH 302																			
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 14 Hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 27 North Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First EDWIN Middle GUY Last NEIKIRK Sr										4. DATE OF DEATH Month October Day 31 Year 1960 19									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67		11. IF UNDER 24 HRS. Days 67		12. IF UNDER 24 HRS. Hours 67		13. IF UNDER 24 HRS. Min. 67		14. IF UNDER 24 HRS. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Nic Natl Branch Bank										10b. KIND OF BUSINESS OR INDUSTRY Hagerstown Wash Co Md.									
11. BIRTHPLACE (State or foreign country) USA										12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME John C. Neikirk										14. MOTHER'S MAIDEN NAME Martha Bowers									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No										16. SOCIAL SECURITY NO. 215-18-2789									
17. INFORMANT Mrs Ima H. Neikirk										Address 27 North Ave									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic heart disease DUE TO years (c) years										INTERVAL BETWEEN ONSET AND DEATH 10 minutes									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure 24 hrs										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19										20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 30 Oct 1960 , to 31 Oct 1960 , that (I) (we) lost saw the deceased alive on 30 Oct 1960 , and that death occurred at 7:45 M, from the causes and on the date stated above.																			
22a. SIGNATURE Eldon D Hoachler M.D.										22b. DATE SIGNED 10/31/60									
22c. PHYSICIAN'S NAME (Type) Eldon D Hoachler										22d. ADDRESS Hagerstown Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 11-3-60									
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery										23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md									
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman										25. REGISTRAR'S SIGNATURE Arthur S. Frank									
ADDRESS Hagerstown Md.										25a. REC'D BY REGISTRAR NOV 2 '60									

CONTINUATION OF DEATH

DATE OF DEATH: 11/11/1911

PLACE OF DEATH: 11/11/1911

BY: 11/11/1911

BY: 11/11/1911

BY: 11/11/1911

BY: 11/11/1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

(M)

11933

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11922

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 57 W. Washington St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN Y NETHERTON		4. DATE OF DEATH Month Day Year October 22 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1887
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carrier Army Man		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Jefferson Co Ky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Netherton		14. MOTHER'S MAIDEN NAME Sally (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W#1		16. SOCIAL SECURITY NO. 086-10-5732	
17. INFORMANT Mrs. Marye K. Netherton		Address 57 W. Washington St Hagerstown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO 48 min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 48 min. DUE TO Acute Pancreatitis (c) 2 hrs.		INTERVAL BETWEEN ONSET AND DEATH 48 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Empyema of the bladder - in - pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 1960 to Oct 22, 1960 that (I) (we) last saw the deceased alive on Oct 21, 1960 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Grupe M.D.		22b. DATE SIGNED 10/22/60	
22c. PHYSICIAN'S NAME (Type) Louis G. GRUPE M.D.		22d. ADDRESS 119 E. Antietam Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/60	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City, town, or county) (State) Wash 60 Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md		25a. REC'D BY REGISTRAR Oct 26 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

11034

CONTINUED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. PR. J. A. MORAN, ST. 115 W. WASHINGTON ST. HAGERSTOWN MD. 081

VR A15 (4)
15M 9/59

11934

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

11923

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>1 HAGERSTOWN MD. R.3</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA ANN NICHOLS</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER 27 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER 15 1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>10 12</u>		IF UNDER 24 HRS. <u>10 12</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LURAY VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOSEPH A. SOURS</u>				14. MOTHER'S MAIDEN NAME <u>EMMA NO RECORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>K.W. NICHOLS HAGERSTOWN MD. R.3.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Abdominal Carcinomatosis</u> DUE TO (c) <u>Carcinoma of Colon</u> 6 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 26, 1960</u> , to <u>OCT 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>OCT 27, 1960</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Moran</u>				22b. PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN</u>		22c. DATE SIGNED <u>OCT 27, 1960</u>	
22d. ADDRESS <u>215 W. WASHINGTON ST. Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>OCT. 30. 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>HAGERSTOWN MD.</u>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. East</u>				25a. REC'D BY REGISTRAR <u>NOV 3 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

RECEIVED
JAN 10 1914
U.S. DEPT. OF AGRICULTURE
WASHINGTON

11134

CERTIFICATE OF DRAIN

MANUAL FOR AGRICULTURAL WORKERS
OF THE UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11935

11924

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RT. #2 HAGERSTOWN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle WILLIS Last NORMAN		4. DATE OF DEATH Month OCTOBER Day 5 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH B. NORMAN		14. MOTHER'S MAIDEN NAME MARY E. SCOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-0270	
17. INFORMANT MRS. MATTIE NORMAN		Address RT. #2 HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 331 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO (c) General Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-24-60 to 10-5-60 , that (I) (we) last saw the deceased alive on 10-4-1960 , and that death occurred at 7 M, from the causes and on the date stated above.			
22a. SIGNATURE J. E. W. [Signature]		22b. DATE 10/7/60	
22c. PHYSICIAN'S NAME (Type) J. E. W. [Signature]		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/7/60	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman		25a. REC'D BY REGISTRAR DATE OCT 10 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

11921

CERTIFICATE OF DEATH

11921

Washington

Washington

WESTERN DISTRICT COURT

JAMES

WILLIS

WILLIS

WILLIS

WILLIS SIOE DOTTEN, JR. CO.

WILLIS SIOE DOTTEN, JR.

JOSEPH E. MORRIS

WILLIS SIOE DOTTEN, JR.

NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11936										11925									
MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Washington MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown										c. LENGTH OF STAY IN 1b 48 years									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital										d. STREET ADDRESS 935 The Terrace									
3. NAME OF DECEASED (Type or print) First ELSA Middle EMMA Last PANGBORN										4. DATE OF DEATH Month October Day 17 Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1884				9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife										10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) New York City				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Christian Schumann										14. MOTHER'S MAIDEN NAME Emma Von den Neinburg									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no										16. SOCIAL SECURITY NO. none				17. INFORMANT Address Mr. Thomas W. Pangborn Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct. 27, 1959 to Oct. 17, 1960 , that (I) (was) last saw the deceased alive on Oct. 17, 1960 , and that death occurred at 2:03 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Donald A. Hoffman										22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Donald A. Hoffman										22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/20/1960				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town, or county) (State) Hagerstown Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Hager										ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE OCT 24 '60				25b. REGISTRAR'S SIGNATURE Charles S. Hume	

11886

11886

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

County of Washington City of Washington

Age 45 years Sex Male Race White

Married Yes Single No Widowed No

Date of Birth October 17, 1900 Date of Death July 28, 1945

Place of Birth U.S.A. Cause of Death Heart Disease

Signature of Physician John Van der ...

Signature of Registrar John ...

Signature of Coroner John ...

Signature of Medical Examiner John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

Signature of ... John ...

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARTIN MANOR REST HOME		d. STREET ADDRESS 1 MAIN ST.	
3. NAME OF DECEASED (Type or print) First Middle Last CORA LOUISE DOFFENBERGER		4. DATE OF DEATH Month Day Year OCTOBER - 7 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 2 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) KEEDYSVILLE WASH. CO. MD. U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JONAS JONES		14. MOTHER'S MAIDEN NAME MARY ELIZABETH LOPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT GROVER DORMAN HAGERSTOWN MD. R. 3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma right breast DUE TO (c) General metastasis INTERVAL BETWEEN ONSET AND DEATH 3-4 days 2-3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) general arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1 19 60 , to Oct 7 19 60 , that (I) (we) lost saw the deceased alive on Oct 6 19 60 , and that death occurred at 3:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III M.D.		22b. DATE SIGNED 10/7/60	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 9, 1960	
23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		23d. LOCATION (City, town, or county) (State) KEEDYSVILLE WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John L. East		25a. REC'D BY REGISTRAR Arthur S. Huns	
25b. REGISTRAR'S SIGNATURE Boonsboro MD.		25c. DATE Oct 11 '60	

I, the undersigned, being a duly qualified Medical Officer of Health for the City of New York, do hereby certify that
 the within and foregoing is a true and correct copy of the original record of the death of
 the person named therein, as the same appears from the records of the Department of Health, City of New York.
 In testimony whereof, I have hereunto set my hand and the seal of the Department of Health, at New York,
 this _____ day of _____, 19____.

 Medical Officer of Health

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

11938

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11927

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 99 Park Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Elizabeth Last Price				4. DATE OF DEATH Month Oct. Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29 1876	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jacob Krontz				14. MOTHER'S MAIDEN NAME Susanna Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Minnie Mills Address Clearspring Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH ? Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sept. 19, 1960				20g. (County) Oct. 5, 1960			
20h. (State) Oct. 5, 1960				20i. (City or town) Oct. 5, 1960			
21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960 to Oct. 5, 1960 that (I) (we) last saw the deceased alive on Oct. 5, 1960 and that death occurred at 10-7-60 M, from the causes and on the date stated above.						22a. SIGNATURE R.A. Bell	
22b. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				22c. ADDRESS Hagerstown, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 8 1960			
23c. NAME OF CEMETERY OR CREMATORY Blairs Valley Cemetery				23d. LOCATION (City, town, or county) Clearspring Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Edna R. ...				25a. REC'D BY REGISTRAR Oct 13 '60			
25b. REGISTRAR'S SIGNATURE ...				25c. RFD #1 ...			

11837

11837

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director may be required by the hospital or attending physician. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11939

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11928

1. PLACE OF DEATH a. COUNTY <u>Western Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>CHARLES Co. MD</u> b. COUNTY <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western MD State Hospital</u>		d. STREET ADDRESS <u>Box - 2</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Samuel</u> Last <u>Queen</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>64</u> yrs.
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHARLES Co. md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>JAMES QUEEN</u>		14. MOTHER'S MAIDEN NAME <u>MADIE DORSEY QUEEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WINDELL QUEEN MD.</u>	
17. INFORMANT <u>WINDELL QUEEN</u>		Address <u>MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary emboli</u> DUE TO <u>Carcinoma of prostate, metastasis to spine</u> DUE TO <u>with compression of spinal cord</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>16 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 24</u> 19 <u>60</u> to <u>Oct. 5</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Oct 5</u> 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u>		22b. DATE SIGNED <u>Oct. 5 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Young E. Chun</u>		22d. ADDRESS <u>Western md. state Hospital, Hagerstown, md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-9-60</u>		23b. DATE THEREOF <u>Smith Chapel</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PISGAH MARYLAND</u>		23d. LOCATION (City, town, or county) (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins</u>		25a. REC'D BY REGISTRAR <u>4804 GA Ave NW.</u>	
25b. REGISTRAR'S SIGNATURE <u>Oct 7 '60</u>		25c. DATE <u>Lincoln S. Kraus</u>	

11088

CENTRAL AVE OF DEATH

Charles Co Md

WINDLE

Western Md State Hospital

1916

PARMER

JAMES QUEEN

NO

Charles Co Md

WINDLE QUEEN

WINDLE QUEEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11981

11929

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. RIZ</u>				d. STREET ADDRESS <u>1 BOONSBORO MD. RIZ</u>			
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>DWIGHT</u> Last <u>REESE</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>73</u> yrs.		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE WASH. CO. ROAD DEPT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. CO. MD. U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. CO. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN REESE</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZA FAULDER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>217-10-3115</u>				17. INFORMANT <u>MRS. BLANCHE EASTERDAY BOONSBORO MD. RIZ</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-2-1959</u> to <u>10-10-1960</u> , that (I) (we) last saw the deceased alive on <u>10-10-1960</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>10/21/60</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>				22d. ADDRESS <u>21 North Main Street Boonsboro, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 23, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Baer</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 25 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

OP

11081

11081

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
WASHINGTON, D. C. 20460

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

TO THE SECRETARY OF THE DEPARTMENT OF HEALTH
FROM THE DIRECTOR OF THE BUREAU OF VETERANS AFFAIRS
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing a matter related to the Bureau of Veterans Affairs.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11940		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND		11930	
CERTIFICATE OF DEATH				302	
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D.O.A d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FairPlay d. STREET ADDRESS 1 Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OTELIA HOMANS REICHARD		4. DATE OF DEATH Month October 21 Day 19 Year 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 21, 1869		9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 12 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Reichard		14. MOTHER'S MAIDEN NAME Anna E. Emmert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Miss. Ruth Reichard, Fairplay Wash Co Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Acute Congestive heart failure DUE TO Chronic Congestive failure DUE TO Atherosclerosis DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vomiting episode		INTERVAL BETWEEN ONSET AND DEATH 12 hr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1958 to Oct 21 1960 that (I) (we) lost the deceased alive on Oct 21 1960 and that death occurred at 1:30 PM , from the causes and on the date stated above.					
22a. SIGNATURE M E Byrkit		22b. DATE 10-23-60		22c. PHYSICIAN'S NAME (Type) M E Byrkit	
22d. ADDRESS 28 W Potomac		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 10-23-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/60		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery	
23d. LOCATION (City, town, or county)		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md		24a. REC'D BY REGISTRAR OCT 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

11380

11380

CERTIFICATE OF DEATH

CHIEF OF BUREAU
U.S. DEPARTMENT OF HEALTH
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

11941

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11931

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 215 Ross St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First PRUDENCE Middle GRACE Last RIDENOUR				4. DATE OF DEATH Month October Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1886	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Mariah Forsyth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-26-5213B		17. INFORMANT Address Mrs. Wm. Shaffer 215 Ross St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hypertension DUE TO (c) Essential Hypertension						INTERVAL BETWEEN ONSET AND DEATH 8 hours Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept 12 19 51 , to Oct 1 19 60 , that (I) (we) last saw the deceased alive on Oct 1 19 60 , and that death occurred at 1035 P. M. from the causes and on the date stated above.							
22a. SIGNATURE L. L. Packer, Jr.				22b. DATE SIGNED Oct 3, 1960			
22c. PHYSICIAN'S NAME (Type) L. L. Packer, Jr., Md.				22d. ADDRESS 145 W. Washington St., Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				25a. REC'D BY REGISTRAR OCT 5 '60			
ADDRESS Hagerstown, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

Wm. A. Horst

1133

1134

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
COUNTY OF WORCESTER
CITY OF WORCESTER
DECEASED
NAME
AGE
SEX
DATE OF BIRTH
DATE OF DEATH
PLACE OF BIRTH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE
MANNER OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF REGISTRAR
CITY OF WORCESTER
MASSACHUSETTS

11942

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11932

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle H Last Robison Jr.				4. DATE OF DEATH Month 10 Day 4 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1957	
9. AGE (In years lost birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 4 Hours 10 Min.		IF UNDER 24 HRS. Months 3 Days 4 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child				10b. KIND OF BUSINESS OR INDUSTRY child		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James H. Robison Sr.				14. MOTHER'S MAIDEN NAME Shirley Heil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. James H. Robison Sr. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Encephalitis 082.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 6 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Md.		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 8-17, 1960 , to 10-4, 1960 , that (I) (we) last saw the deceased alive on 10-3, 1960 , and that death occurred at 8:35 AM , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-5-60	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.				22d. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-6-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss			

MEDICAL CERTIFICATION

11048

CERTIFICATE OF DEATH

11035

Name of Deceased		Date of Death	
John A. Robinson		Jan 15 1917	
Age		35	
Sex		Male	
Race		White	
Married		Yes	
Spouse		Mary A. Robinson	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		J. H. Smith	
Signature of Registrar		J. H. Smith	
Date of Registration		Jan 15 1917	
Place of Registration		City of New York	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 1/2 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
f. STREET ADDRESS 34 W. Water St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lilah Middle Cathryn Last Ross		4. DATE OF DEATH Month Oct. Day 15 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 4 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY public schools	
11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Ross		14. MOTHER'S MAIDEN NAME Sarah Hause	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles H. Ross, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331 X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO Generalized Arteriosclerosis (c) Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumatic Heart Disease, Metastatic Carcinoma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 12 , 19 60 , to Oct 15 , 19 60 , that I last saw the deceased alive on Oct 15 , 19 60 , and that death occurred at 1:00 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. P. Landigason		ADDRESS (Street, city or town, state) 12 South Main Smithsburg, Md.	
PHYSICIAN'S NAME (Type) E. P. Landigason, M.D.		DATE SIGNED 10-17-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-18-60	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REGISTERED BY REGISTRAR Oct 18 60	
24b. REGISTRAR'S SIGNATURE Robert J. Minnich		DATE	

14933

CERTIFICATE OF DEATH

Washington

Neversown

24 hours

Smithsburg

Washington County Hospital

34 W. Water St.

William

Cathryn

Rosa

Oct. 12, 1900

June 20, 1871

Female

Public School, Thawville, Md.

Teacher

Henry Ross

Smithsburg

none

Charles H. Ross, Smithsburg, Md.

no

Serial

10-18-10

Smithsburg Cemetery, Smithsburg, Md.

Scott V. Smith & Son, Smithsburg, Md.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
11944
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11934

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. NAME OF HOSPITAL (If not in hospital, give street address) OR WASHINGTON WASHINGTON CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL NR. CLEAR SPRING, MD d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle ROWLAND Last ROWLAND		4. DATE OF DEATH Month OCTOBER Day 6 Year 1960						
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1896	9. AGE (In years lost, birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 64	11. IF UNDER 24 HRS. Days 64	12. IF UNDER 48 HRS. Hours 64	13. IF UNDER 72 HRS. Min. 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) BLAIRS VALLEY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LEWIS ROWLAND		14. MOTHER'S MAIDEN NAME MINERVA SUFFACOO						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 214-36-0282		17. INFORMANT MRS BLANCHE ROWLAND		Address BLAIRS VALLEY, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO 420.1 CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION 17 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) CORONARY ARTERY ATHEROSCLEROSIS DUE TO (c) UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ATELECTASIS OF THE RIGHT LOWER LOBE OF THE LUNG								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from SEPT. 20 19 60 to OCTOBER 6 19 60 , that (I) (we) last saw the deceased alive on OCTOBER 6 19 60 , and that death occurred at 6.00AM M, from the causes and on the date stated above.								
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED OCTOBER 7, 1960				
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		22d. ADDRESS CLEAR SPRING, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 8, 1960		23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town, or county) (State) NR. CLEAR SPRING, MD.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>		ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR OCT 10 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

582 EL

3218

YAK-01 = 19170528H ALMAZ Y 19170528Z Y YTTA Y 19170528Z

Y Y

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11945

11935

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Washington		MARYLAND		a. STATE Md.		b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 58 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1 31 Randolph Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First George		Middle Albertus		Last Rudisill		Month Day Year Oct. 3, 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 3, 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY cabinet work		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Rudisill				14. MOTHER'S MAIDEN NAME Catherine Rudisill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-2618		17. INFORMANT Anita Rudisill, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HemiPlegic due to old fracture of cervical spine							INTERVAL BETWEEN ONSET AND DEATH 8 me.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 55		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1955 to Oct. 3, 1960 , that (I) (we) last saw the deceased alive on Oct 3, 1960 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				22d. ADDRESS 214 N. Potomac St, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-6-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son,				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

712 6000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Greencastle PA2</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>75X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Curtis</u> Middle <u>Rupert</u> Last <u>Rupert</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highway Const.</u>	11. BIRTHPLACE (State or foreign country) <u>Huntingdon Co. Pa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Rupert</u>	
14. MOTHER'S MAIDEN NAME <u>Vera Elizabeth Chilcote</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Jesse Rupert - Three Springs, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>SEVERAL YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DR. E.W. DITTO, JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 3 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hustontown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hustontown Fulton Co. Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J McClain</u>		ADDRESS <u>Cassville, Pa.</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

11386

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11346

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH 10/15/1914		6. PLACE OF DEATH New York City	
7. TIME OF DEATH 10:00 AM		8. PLACE OF BIRTH New York City	
9. OCCUPATION Clerk		10. MARITAL STATUS Married	
11. CAUSE OF DEATH General arteriosclerosis		12. MANNER OF DEATH Natural	
13. SIGNATURE OF EXAMINER J. J. Jones		14. SIGNATURE OF WITNESSES J. J. Jones	
15. SIGNATURE OF REGISTRAR J. J. Jones		16. SIGNATURE OF CLERK J. J. Jones	

1

DR. E. W. DITTO, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11982

CERTIFICATE OF DEATH

11937
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pen Mar</u>		c. LENGTH OF STAY IN 1b <u>24 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pen Mar</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Sease</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6,</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mountaintown Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Carson</u>		14. MOTHER'S MAIDEN NAME <u>Loretta Cline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Genieve Baker, Pen Mar Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arterio-Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-15-60</u> , 19 <u>60</u> , to <u>10-6-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/6</u> , 19 <u>60</u> , and that death occurred at <u>11:50 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Brown</u> M.D.		ADDRESS (Street, city or town, state) <u>Waynesboro Pa.</u>	
PHYSICIAN'S NAME (Type) <u>R. B. BROWN M.D.</u>		DATE SIGNED <u>WAYNESBORO PA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Grove, Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

11983

<p>1. Name of deceased: <u>ALMA BROWN</u></p>		<p>2. Sex: <u>F</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>USA</u></p>	
<p>5. Date of death: <u>1983</u></p>		<p>6. Place of death: <u>USA</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1983</u></p>		<p>12. Place of registration: <u>USA</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

11947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11938

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SERENA Middle EDITH Last SEE		4. DATE OF DEATH Month October Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1960
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert G. See		14. MOTHER'S MAIDEN NAME Marian Brock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Robert G. See		Address Maugansville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Defect 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mongolism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes birth		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 2 1960 to Oct. 8 1960 , that (I) (we) last saw the deceased alive on 10-8-60 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE D. J. Boyer		22b. DATE SIGNED 10-10-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 135 No. Pot St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/60	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town, or county) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Frankling Boyer		25a. REC'D BY REGISTRAR DATE OCT 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS Hagerstown, Maryland	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11948

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11939

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Robinsonville Pennsylvania</u>	
c. LENGTH OF STAY IN lb <u>2 weeks</u>		d. STREET ADDRESS <u>Robinsonville 75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Ford Sellers</u>		4. DATE OF DEATH Month Day Year <u>10 22 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Bedford Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Leighty</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Minnich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ruth E. Long Clearville Pa. RD #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>59</u> to <u>10/22</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>10/21</u> 19 <u>60</u> and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>George Jennings MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George Jennings</u>		22d. ADDRESS <u>136 W. Washington St. Hagerstown, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/24/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Robinsonville ME Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Bedford Co. Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Shore Hancock Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur D. Riney</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11983
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11940

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maugansville, md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDITA</u> First <u>C.</u> Middle <u>SHANK</u> Last		4. DATE OF DEATH <u>OCT 25</u> Month <u>1960</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1881</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Rutherford</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Metz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in army) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Gladys Shank - Maugansville, md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>420.0</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia right lower lobe</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 22 1950</u> death, 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>October 25, 1960</u> and that death occurred at <u>3:05 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Keadle</u> 23		22b. DATE SIGNED <u>10-26-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u>		22d. ADDRESS <u>318 N. Potomac St.,agerstown, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>10/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ruff Church Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Cearfoos, md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle Pa</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 31 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11949

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11941

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 20 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 Calvert Terrace				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 120 Calvert Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WONGER SHANK Sr				4. DATE OF DEATH Month Day Year October 17 1960 19											
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10 1892		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Hag Shoe Co				11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Benjamin Shank				14. MOTHER'S MAIDEN NAME Elizabeth Braper											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.# 1 214-09-0117		17. INFORMANT Mrs Eloise W. Shank 120 Calvert Ter.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with Aortic Stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Aortic insufficiency DUE TO (c) 50 yrs INTERVAL BETWEEN ONSET AND DEATH 50 yrs												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2-24 1948 to 10-17 1960 that (I) (we) last saw the deceased alive on 10-17 1960 , and that death occurred at 12:30 AM from the causes and on the date stated above.															
22a. SIGNATURE Dalton M. Welty M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-17-60							
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.						22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/19/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town, or county) Hagerstown Wash Co Md. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						ADDRESS		25a. REC'D BY REGISTRAR Oct 20 1960 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11984

11942

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>			
c. LENGTH OF STAY IN 1b <u>5 YEARS</u>				d. STREET ADDRESS <u>HAGERSTOWN MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. R.I.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ISIAH SLICK</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER - 16 - 1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 29 - 1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE WASH. CO. ROAD DEPT.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LEITERSBURG WASH. CO. MD. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ELMER SLICK</u>			14. MOTHER'S MAIDEN NAME <u>MARY SHOWE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>214-09-9640</u>		17. INFORMANT Address <u>MRS. NINA SLICK HAGERSTOWN MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aдено-сарсарома of right lung</u> 163X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>10-16 - 1960</u> to <u>10-16 - 1960</u> , that (I) (we) last saw the deceased alive on <u>10-16 - 1960</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>JOSEPH SECONDARI</u>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10/18/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>		22d. ADDRESS <u>21 North Main St. Boonsboro, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John C. East</u>			ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11884

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE
WASHINGTON, D. C.

11884



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

11950

CERTIFICATE OF DEATH

Reg. Dist. No. 11944

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 21 W. Antietam Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Craig Middle NMN Last Spielman				4. DATE OF DEATH Month Oct. Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1960	
9. AGE (In years lost birthday) yrs. 9		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Harry Spielman, Jr.				14. MOTHER'S MAIDEN NAME Mary Jane Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immature birth, neonatal death DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 776X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 19, 1960 , to Oct. 20, 1960 , that I last saw the deceased alive on Oct. 20, 1960 , and that death occurred at 2:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Dr. H. N. Weeks							
ACTUAL SIGNATURE Dr. H. N. Weeks M.D.							
PHYSICIAN'S NAME (Type) Dr. H. N. Weeks Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/24/60		22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hosp. Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				24a. REC'D BY REGISTRAR DATE OCT 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

CERTIFICATE OF DEATH

11945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1421 W. Antietam Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Curtis Middle NMN Last Spielman		4. DATE OF DEATH Month Oct. Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1960
9. AGE (In years lost birthdays) yrs. 15 Months 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Spielman, Jr.		14. MOTHER'S MAIDEN NAME Mary Jane Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immature birth, neonatal death DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Oct. 19, 1960 , to Oct. 20, 1960 , that I last saw the deceased alive on Oct. 20, 1960 , and that death occurred at 9:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <i>Dr. H. N. Weeks</i>		M.D. _____	
PHYSICIAN'S NAME (Type) Dr. H. N. Weeks		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/24/60	
22c. NAME OF CEMETERY OR CREMATORY Wash. County Hospital Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. H. N. Weeks</i>		24a. REC'D BY REGISTRAR DATE OCT 28 '60	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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CERTIFICATE OF DEATH

NAME OF DECEASED Washington		DATE OF BIRTH 1901		PLACE OF BIRTH Maryland	
SEX Male		AGE 31 years		OCCUPATION None	
DATE OF DEATH Oct. 19, 1930		PLACE OF DEATH Washington County Hospital		CAUSE OF DEATH Pneumonia	
TIME OF DEATH 10:30 A.M.		MANNER OF DEATH Natural		DISEASE OR INJURY Pneumonia	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL Washington County Hospital		NAME OF NURSE Miss J. H. Smith	
NAME OF FUNERAL HOME None		NAME OF BURIAL PLACE None		NAME OF MINISTER None	
NAME OF WITNESS None		NAME OF SECOND WITNESS None		NAME OF THIRD WITNESS None	
NAME OF REGISTRAR None		NAME OF CLERK None		NAME OF ASSISTANT CLERK None	
NAME OF DECEASED'S MOTHER None		NAME OF DECEASED'S FATHER None		NAME OF DECEASED'S SPOUSE None	
NAME OF DECEASED'S BROTHER None		NAME OF DECEASED'S SISTER None		NAME OF DECEASED'S CHILDREN None	
NAME OF DECEASED'S GRANDFATHER None		NAME OF DECEASED'S GRANDMOTHER None		NAME OF DECEASED'S UNCLE None	
NAME OF DECEASED'S AUNT None		NAME OF DECEASED'S NEPHEW None		NAME OF DECEASED'S NIECE None	
NAME OF DECEASED'S COUSIN None		NAME OF DECEASED'S FIRST COUSIN None		NAME OF DECEASED'S SECOND COUSIN None	
NAME OF DECEASED'S THIRD COUSIN None		NAME OF DECEASED'S FOURTH COUSIN None		NAME OF DECEASED'S FIFTH COUSIN None	
NAME OF DECEASED'S SIXTH COUSIN None		NAME OF DECEASED'S SEVENTH COUSIN None		NAME OF DECEASED'S EIGHTH COUSIN None	
NAME OF DECEASED'S NINTH COUSIN None		NAME OF DECEASED'S TENTH COUSIN None		NAME OF DECEASED'S ELEVENTH COUSIN None	
NAME OF DECEASED'S TWELFTH COUSIN None		NAME OF DECEASED'S THIRTEENTH COUSIN None		NAME OF DECEASED'S FOURTEENTH COUSIN None	
NAME OF DECEASED'S FIFTEENTH COUSIN None		NAME OF DECEASED'S SIXTEENTH COUSIN None		NAME OF DECEASED'S SEVENTEENTH COUSIN None	
NAME OF DECEASED'S EIGHTEENTH COUSIN None		NAME OF DECEASED'S NINETEENTH COUSIN None		NAME OF DECEASED'S TWENTIETH COUSIN None	
NAME OF DECEASED'S TWENTY-FIRST COUSIN None		NAME OF DECEASED'S TWENTY-SECOND COUSIN None		NAME OF DECEASED'S TWENTY-THIRD COUSIN None	
NAME OF DECEASED'S TWENTY-FOURTH COUSIN None		NAME OF DECEASED'S TWENTY-FIFTH COUSIN None		NAME OF DECEASED'S TWENTY-SIXTH COUSIN None	
NAME OF DECEASED'S TWENTY-SEVENTH COUSIN None		NAME OF DECEASED'S TWENTY-EIGHTH COUSIN None		NAME OF DECEASED'S TWENTY-NINTH COUSIN None	
NAME OF DECEASED'S THIRTIETH COUSIN None		NAME OF DECEASED'S THIRTY-FIRST COUSIN None		NAME OF DECEASED'S THIRTY-SECOND COUSIN None	
NAME OF DECEASED'S THIRTY-THIRD COUSIN None		NAME OF DECEASED'S THIRTY-FOURTH COUSIN None		NAME OF DECEASED'S THIRTY-FIFTH COUSIN None	
NAME OF DECEASED'S THIRTY-SIXTH COUSIN None		NAME OF DECEASED'S THIRTY-SEVENTH COUSIN None		NAME OF DECEASED'S THIRTY-EIGHTH COUSIN None	
NAME OF DECEASED'S THIRTY-NINTH COUSIN None		NAME OF DECEASED'S FORTIETH COUSIN None		NAME OF DECEASED'S FORTY-FIRST COUSIN None	
NAME OF DECEASED'S FORTY-SECOND COUSIN None		NAME OF DECEASED'S FORTY-THIRD COUSIN None		NAME OF DECEASED'S FORTY-FOURTH COUSIN None	
NAME OF DECEASED'S FORTY-FIFTH COUSIN None		NAME OF DECEASED'S FORTY-SIXTH COUSIN None		NAME OF DECEASED'S FORTY-SEVENTH COUSIN None	
NAME OF DECEASED'S FORTY-EIGHTH COUSIN None		NAME OF DECEASED'S FORTY-NINTH COUSIN None		NAME OF DECEASED'S FIFTIETH COUSIN None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div> <div>11952</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> </div> <div>11946</div> </div> <div>CERTIFICATE OF DEATH</div>									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro rural</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>					d. STREET ADDRESS <u>10X-2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Maye</u> Last <u>STAUB</u>					4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1889</u>		9. AGE (In years last birthday) yrs. <u>71</u>	
						IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Stoops</u>					14. MOTHER'S MAIDEN NAME <u>Liza Kettoman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Paul Zoerb Lewistown, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary anemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gastrointestinal bleeding</u> DUE TO (c) <u>diverticulosis</u>									INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>4 years</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6, 1960</u> to <u>Oct 11, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct 11, 1960</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Victor L. Ramos</u>					22b. DATE SIGNED <u>Oct. 12, 1960</u>				
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos</u>					22d. ADDRESS <u>Western Md. State Hospital, 1500 Pennsylvania Ave., Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10-15-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Creagerstown, Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Creagerstown Fred. Co.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Creager</u>					ADDRESS <u>Thurmont, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

11008

CERTIFICATE OF DEATH

11255



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11947
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			c. LENGTH OF STAY IN 1b 65 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 137 N. Artizan St.				d. STREET ADDRESS 137 N. Artizan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Gertrude Middle Helen Last Steffey				4. DATE OF DEATH Month Oct. Day 4 Year 19 60				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15 1881		
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18		11. IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Charlton Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Samuel Gruber				14. MOTHER'S MAIDEN NAME Catherine Brubaker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William Steffey				
				Address 137 N. Artizan St. Williamsport Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia due to chronic blood loss DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix & widespread DUE TO (c) Pelvic METASTASES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.								
22a. SIGNATURE John A. Moran				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/5/60		
22c. PHYSICIAN'S NAME (Type) JOHN A. MORAN M.D.				22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 7 1960		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Edith C. [Signature]				ADDRESS Williamsport Md.		25a. REC'D BY REGISTRAR DATE OCT 6 '60		
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11948

11953

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>ONE MONTH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>BOONSBORO MD. R12</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Woodrow Andrew Stottlemeyer</u>				4. DATE OF DEATH Month Day Year <u>October 27, 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 14 - 1914</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER WILLIAMS CONSTRUCTION CO.</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>	
13. FATHER'S NAME <u>WEBSTER STOTTELMYER</u>				14. MOTHER'S MAIDEN NAME <u>LORA RIDENOUR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-10-3939</u>		17. INFORMANT <u>MRS. EVA STOTTELMYER</u> Address <u>BOONSBORO MD. R12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized lymphosarcomatosis</u> DUE TO (c) <u>2 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 26, 1960</u> to <u>October 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>October 27, 1960</u> , and that death occurred at <u>2:55</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u> M.D.				22b. DATE SIGNED <u>Oct. 27, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Young E. Chun</u>				22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 30 - 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u> ADDRESS <u>BOONSBORO MD</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 3 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thoms</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11954

11949

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Pany Last Stubits				4. DATE OF DEATH Month Oct. Day 7, Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1904	
9. AGE (In years lost birthday) yrs. 55		10. UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress				10b. KIND OF BUSINESS OR INDUSTRY ladies apparel		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME Joseph Pany				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-8593		17. INFORMANT Ignatz Stubits, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4 43X IMMEDIATE CAUSE (a) Nephrosclerosis DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive CV Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/19 19 60 , to 10/8 19 60 , that (I) (we) last saw the deceased alive on 10/7 19 60 , and that death occurred at 12P M, from the causes and on the date stated above.							
22a. SIGNATURE Robert V. Campbell				22b. DATE SIGNED 10/8/60			
22c. PHYSICIAN'S NAME (Type) Robert V. Campbell				22d. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 10 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knaub	

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may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11955

11950

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write HAGERSTOWN and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write HAGERSTOWN and give nearest town)			
c. LENGTH OF STAY IN 1b LIFE				d. STREET ADDRESS 115 SNYDER AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY GIRL SWEENEY				4. DATE OF DEATH OCTOBER 13 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/60	
9. AGE (In years last birthday) 15 1/2		IF UNDER 1 YEAR Months 15 Days 15		IF UNDER 24 HRS. Hours 15 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME DELORES MAXINE SWEENEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ADMER SWEENEY		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity + Atelectasis DUE TO 7 62 - 5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 15 1/2 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-13 1960 , to 10-13 1960 , that (I) (we) last saw the deceased alive on 10-13 1960 , and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE Samuel F. Woodrill				22b. DATE SIGNED 10-14-60		22c. PHYSICIAN'S NAME (Type) Samuel F. Woodrill	
22d. ADDRESS 115 King St. Hagerstown, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/14/60		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

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11956

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11951

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 38 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS 23 S. Foundry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha First May Middle THOMAS Last		4. DATE OF DEATH 10 Month 20 Day 1960 Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1902	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Great Cacapon, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Calvin Divelbiss		14. MOTHER'S MAIDEN NAME Ada Stinebaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Harry Hull Address Big Pool, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Bilateral hydronephrosis and hydroureter DUE TO (c) Carcinoma of Cervix uteri CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 16, 1960 to Oct. 20, 1960 , that (I) (we) last saw the deceased alive on Oct. 20, 1960 and that death occurred at 8:40 from the causes and on the date stated above.					
22a. SIGNATURE Young E. Chun		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 20, 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Young E. Chun		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City, town, or county) Hagerstown		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR OCT 24 60 DATE	
25b. REGISTRAR'S SIGNATURE William G. Horst					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11957

11952

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMELIA Middle YOUNES Last TOOMA		4. DATE OF DEATH Month October Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1896
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Tripoli, Lebanon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Younes Barkett		14. MOTHER'S MAIDEN NAME Meleke Gazell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mr. Fred A. Tooma		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fibrillation + myocardial failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 4 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 56 to 8 Oct 1960 , that (I) (we) last saw the deceased alive on 7 Oct 1960 , and that death occurred at 1220 AM from the causes and on the date stated above.			
22a. SIGNATURE F. F. Lusby		22b. DATE SIGNED 10/10/60	
22c. PHYSICIAN'S NAME (Type) F. F. Lusby		22d. ADDRESS 2301 Potomac St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer		25a. REC'D BY REGISTRAR DATE OCT 13 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TABLE 1.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11953

Reg. Dist. No.

11953

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>on Arrival at Washington Co. Hospital</u>				d. STREET ADDRESS <u>414 E. Baltimore st</u>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Benjamin</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 3, 1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penna Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Car Inspector</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Calvin Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Hawbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-09-5445</u>		17. INFORMANT <u>Mrs. Mary Thompson, Greencastle, Pa</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ several yrs.						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. W. Ditto Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. W. Ditto Jr., M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/26/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broad Grening Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington Co. Maryland</u> (State) _____		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard M. Zimmerman, Greencastle Pa.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE OCT 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kirsch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11954
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11959
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Ferdinand Weagly Sr.		4. DATE OF DEATH Oct... 20 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1883
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor W.M.R.R.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Weagly		14. MOTHER'S MAIDEN NAME Samantha J. Weagly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Rena Weagly		Address Hagerstown 470 Pangborn Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerosis, one heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 wks.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/25 19 60 to Oct 20 19 60 that (I) (we) last saw the deceased alive on Oct 20 19 60 , and that death occurred at 330 M, from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 10/4/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-23-60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25. REC'D BY REGISTRAR OCT 25 '60	
ADDRESS Hagerstown Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11004

CENTINATE DE DEATH

11000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11955

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 * days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 319 Radcliff Ave.	
3. NAME OF DECEASED (Type or print) First TROY Middle LEE Last WEIKERT		4. DATE OF DEATH Month October Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray I. Weikert, Jr.		14. MOTHER'S MAIDEN NAME Evelyn Redmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ray I. Weikert, Jr. Hagerstown, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **Sept 28, 1960** to **Oct 1, 1960** that (I) (we) last saw the deceased alive on **Oct 1, 1960** and that death occurred at **7:00 PM**, from the causes and on the date stated above.

22a. SIGNATURE L. L. Packer, Jr.	22b. DATE SIGNED Oct 3, 1960
22c. PHYSICIAN'S NAME (Type) L. L. Packer, Jr., M.D.	22d. ADDRESS 1145 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/3/1960	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
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24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Beyer	ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR DATE OCT 6 '60	25b. REGISTRAR'S SIGNATURE Charles S. Fennell
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TO DE **MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11956									
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock (Rural)</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROUTE #40</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>W.Va</u> b. COUNTY <u>MORGAN</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Berkeley Springs</u> d. STREET ADDRESS <u>R.F.D. #1</u> <u>85X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>WILLIE WRIGHTON WIDMEYER</u> First Middle Last 4. DATE OF DEATH <u>OCT. 30</u> 19 <u>60</u> Month Day Year					5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>OCT. 10, 1894</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRECHARDIST</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>CRECHARD</u> 11. BIRTHPLACE (State or foreign country) <u>MORGAN Co., W.Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>WILLIAM WIDMEYER</u> 14. MOTHER'S MAIDEN NAME <u>LAURA V. ROCKWELL</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>236-548742</u> 17. INFORMANT <u>D. Widmyer</u> Address <u>Berkeley Springs, W.Va</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest (Fracture of left ribs)</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Fracture of rib causing Hemorrhage</u> DUE TO (c) <u>Compound Compound Fracture left leg</u> fracture PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Auto collision 1 mi W Hancock on B 40</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>845 am 10-30 1960</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B# 40</u> 20f. (City or town) <u>Hancock</u> (County) <u>Washington</u> (State) <u>MD</u>					21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>S. E. Smith</u> EXAMINER'S NAME (Type) <u>J. F. W. Smith Jr</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>Nov. 2, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>GREENWAY</u> 22d. LOCATION (City, town, or country) (State) <u>Berkeley Springs W.Va</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/30/60</u> Address (Street, city, town, or county)				
23. FUNERAL DIRECTOR <u>John H. Smith</u> ADDRESS <u>Berkeley Springs, W.Va</u> 24a. REC'D BY REGISTRAR <u>NOV 1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>									

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11961
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11957

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last WILSON				4. DATE OF DEATH Month October Day 24 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 22, 1960	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME Robert Wilson				14. MOTHER'S MAIDEN NAME Maggie Loveless			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Robert Wilson Hagerstown, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ret Esanta Fi Bro Physia Drunk DUE TO Drunk Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drunk DUE TO Drunk (c) Drunk INTERVAL BETWEEN ONSET AND DEATH 1 Day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Drunk							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/23/60 to 10/24/60 , that (I) (we) last saw the deceased alive on 10/24/60 , and that death occurred at 11 M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Franklin Boyer				22b. DATE SIGNED 10/24/60			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/25/1960			
23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery				23d. LOCATION (City, town, or county) (State) Bakersville Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer				25a. REC'D BY REGISTRAR Arthur S. Kline			
25b. REGISTRAR'S SIGNATURE Arthur S. Kline				25c. DATE OCT 28 '60			

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UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11962

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11958

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 42 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 531 N. Locust St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle HARPER Last WOLFE				4. DATE OF DEATH Month October Day 14 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 11, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 14 Hours 14 Min.		IF UNDER 24 HRS. Months 6 Days 14 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Dealer		11. BIRTHPLACE (State or foreign country) Mt. Jackson, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Wolfe				14. MOTHER'S MAIDEN NAME Amanda Funkhouser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-3280		17. INFORMANT Mrs. Elizabeth Coffman Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Uremia - Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Glomerular Nephritis DUE TO Anterior Sclerotic Heart Disease (c) 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 yrs 10 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1934 , to 10/14/60 , that (I) (we) last saw the deceased alive on 10/13/60 , and that death occurred at 6:30 M, from the causes and on the date stated above.							
22a. SIGNATURE SEARL YOUNG				22b. DATE SIGNED 10/14/60			
22c. PHYSICIAN'S NAME (Type) SEARL-YOUNG M.D.				22d. ADDRESS 148 N POTOMAC HAGERSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home P. J. J. J. J.				25a. REC'D BY REGISTRAR DATE OCT 18 '60			
ADDRESS Hagerstown, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Received 1 August 2003

DATE: 05-03-05

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CENTRAL OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

CERTIFICATE OF DEATH

11960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Craig Middle Armstrong Last Yost		4. DATE OF DEATH Month Oct. Day 30 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1960
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 18	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles LeRoy Yost, Jr.		14. MOTHER'S MAIDEN NAME Helen Elaine Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. Medical Record	
17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congenital cardiac defect DUE TO 754.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple congenital defect DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 29, 19 60 , to Oct. 30, 19 60 , that I last saw the deceased alive on Oct. 30, 19 60 , and that death occurred at 12:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Harold H. Gist		M.D.	
PHYSICIAN'S NAME (Type) Dr. H. H. Gist		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/1/60	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hosp. Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold H. Gist		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

11987

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11961

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROWNSVILLE - RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROWNSVILLE - RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BROWNSVILLE NID				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH PAULINE YOURTEE				4. DATE OF DEATH OCTOBER 19, 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 13, 1870	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 9 Days 6	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BROWNSVILLE WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. JOHN T. YOURTEE				14. MOTHER'S MAIDEN NAME ANNE BOTELEK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT COL. LEON R. YOURTEE Address BROWNSVILLE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) acute congestive heart failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/13, 1960 to 10/19, 1960 that (I) (we) last saw the deceased alive on 10/19, 1960 and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE W B Carpenter				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) W B Carpenter	
22d. ADDRESS Louettsville, Virginia				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 22, 1960		23c. NAME OF CEMETERY OR CREMATORY ST. LUKES EPISCOPAL CEMETERY		23d. LOCATION (City, town, or county) (State) BROWNSVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Best				25a. REC'D BY REGISTRAR Boonsboro MD.		25b. REGISTRAR'S SIGNATURE Charles S. House	

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CERTIFICATE OF DEATH

11381

WILLIAM J. HARRIS

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